

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City/ST/Zip: _____
 Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm
Patient Status: New to Therapy Dose or Frequency Change Order Renewal

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

DIAGNOSIS*

***ICD 10 Code
Required**

- Migraine without aura (G43.00-G43.019), ICD10 _____
- Migraine with aura (G43.10-G43.119), ICD10 _____
- Chronic migraine without aura (G43.70-G43.719), ICD10 _____
- Other migraine (G43.80-G43.839), ICD10 _____
- Migraine, unspecified (G43.90-G43.919), ICD10 _____
- Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Vyepti® (eptinezumab)	<input type="checkbox"/> 100mg <input type="checkbox"/> 300mg	Infuse IV over 30 minutes once every 3 months x 1 year

Is patient currently receiving therapy above from another facility?

Yes No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

- No premeds ordered at this time
- Acetaminophen 650mg PO Diphenhydramine 25mg PO
- Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IVP
- Other: _____

LAB ORDERS

- Labs to be drawn by:** Infusion Center Referring Physician
- No labs ordered at this time
 - CBC q _____ CMP q _____ CRP q _____
 - ESR q _____ LFTs q _____ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
 Physician Name: _____ Provider NPI: _____ Specialty: _____
 Address: _____ City/ST/Zip: _____
 Contact Person: _____ Phone #: _____ Fax #: _____
 Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

- Vyepti is being used as prophylaxis for migraine(s).
- The patient has episodic or chronic migraine diagnosis as evidenced by the following over the last 3 months:
 - Episodic Migraine
 - Average Number of Migraine Days Per Month: _____
 - Average Number of Headaches Per Month: _____
 - Chronic Migraine
 - Average Number of Migraine Days Per Month: _____
 - Average Number of Headaches Per Month: _____

PRIOR FAILED THERAPIES (including antidepressant, beta-blocker, anti-epileptic, anti-hypertensive, and botulinum toxin)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
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