

EPTINEZUMAB-JJMR (VYEPTI®) PRESCRIBER ORDER FORM		
FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128		
<input type="checkbox"/> NEW PATIENT OR <input type="checkbox"/> CHANGE ORDER: <input type="radio"/> Drug Change <input type="radio"/> Dose Change <input type="radio"/> Interval Change		
Patient Name:		Date of Birth:
Phone:		Gender:
Address:		
Allergies:		
Height: <input type="checkbox"/> in <input type="checkbox"/> cm Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg		
CLINICAL INFORMATION		
Primary Diagnosis Description:		ICD-10 Code:
Medications previously tried and failed (list medication and duration of use):		Has patient received Botox®? <input type="checkbox"/> Yes: # of injections _____ <input type="checkbox"/> No
PRESCRIPTION		
For existing Vyepti® patients: Date of last infusion: _____ Vyepti® (Eptinezumab-jjmr) refill as directed x 1 year) <input type="checkbox"/> Infuse 100mg IV over 30 minutes once every 3 months. <input type="checkbox"/> Infuse 300mg IV over 30 minutes once every 3 months. Using a 50mL 0.9% Sodium Chloride IV bag, flush IV tubing with NS 10 to 20 mL after each infusion Infuse via a 0.2 micron in-line filter Dispense quantity sufficient of Vyepti® 100mg single dose vials for each dose		
ANCILLARY ORDERS		
Pre-Medication Orders <input type="checkbox"/> Cetirizine 10mg IV 30 minutes before infusion. <input type="checkbox"/> Other: _____ Refill above ancillary orders as directed x 1 year.		
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>		
Prescriber Signature:		Date:
PRESCRIBER INFORMATION		
Prescriber Name:	Phone:	Fax:
Address:		NPI:
City, State, Zip:	Office Contact:	
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