Virginia Oncology Associates
MSIC
Multispecialty Infusion Clinic

(757) 271-0969 call
(757) 466-1128 fax

EPTINEZUMAB-JJMR (VYEPTI®) PRESCRIBER ORDER FORM

FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128

☐ **NEW PATIENT OR**
☐ **CHANGE ORDER:** ○ **Drug Change** ○ **Dose Change** ○ **Interval Change**

Patient Name:	Date of Birth:
Phone:	Gender:
Address:	
Allergies:	
Height: ☐ in ☐ cm Weight: ☐ lbs ☐ kg	

CLINICAL INFORMATION

Primary Diagnosis Description:	**ICD-10 Code:**
Medications previously tried and failed (list medication and duration of use):	Has patient received Botox®? ☐ Yes: # of injections _____ ☐No

PRESCRIPTION

For existing Vyepti® patients: Date of last infusion: _____

Vyepti® (Eptinezumab-jjmr) refill as directed x 1 year)

☐ Infuse 100mg IV over 30 minutes once every 3 months.
☐ 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

☐ Cetirizine 10mg IV 30 minutes before infusion.
☐ Other: _____

Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

PRESCRIBER INFORMATION

Prescriber Name:	**Phone:**	**Fax:**
Address:		**NPI:**
City, State, Zip:	**Office Contact:**	