



Vyepti® Referral Form



PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com Initial order Reorder

Demographics Information: Today's Date _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Phone #: _____ Cell Alternate Phone #: _____ Cell

Height: _____ in/ft **Weight:** _____ lbs/kg Date weight recorded: _____ **Last 4 of SSN:** _____

Allergies: _____ NKDA

Diagnosis Information: Migraine without aura, not intractable G43.00 Migraine without aura, intractable G43.01
 Migraine with aura, not intractable G43.10 Migraine with aura, intractable G43.11
 Other Diagnosis/ICD10Code _____

Date Infusion to Begin: _____	Is this a first infusion? <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Last Infusion: _____
List Reactions: _____	List of Failed Therapies: _____

Assessment Questions: *Please Provide Appropriate Documentation*

Diabetes? Yes No HTN? Yes No Cardiac History? Yes No Difficulty Breathing? Yes No
 Requires Oxygen? Yes No Confusion /Disorientation? Yes No Neuro History? Yes No

Vyepti® (Eptinezumab-jjmr): J3032

Dose: 100mg IV over 30 minutes every 12 weeks for 12 months or _____ months

Other dose: _____ mg IV over 30 minutes every 12 weeks for 12 months or _____ months

Pre-Medications: Patient to Provide and take 30 minutes prior to infusion. Will receive 50 ml of 50ml bag of NS post- infusion.

Acetaminophen 325 mg PO x1 Acetaminophen 650 mg PO x1
 Benadryl 50mg PO X1 Benadryl 25 mg Po x1
 Other Pre-medication: _____

<p>Access: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC Route: <input type="checkbox"/> IV</p> <p>Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency</p> <p>PIV – NS 5ml: Qty 3</p> <p>PORT – NS 10ml: Qty 3, Heparin 5mL 100units/mL x 1 per infusion.</p> <p>PICC – NS 10ml:Qty 3, Heparin 5mL 10units/mL x 1 per infusion</p>	<p>Supplies: (please strike through if not required)</p> <p>Administration Supplies (A4222) – 1 per infusion Catheter Care Supplies (A4221) – 1 per week Infusion Pump (E0781) Nursing services to administer medications</p> <p>Administration through an in-line 0.2-micron or less, sterile, nonpyrogenic, low-protein binding filter is required</p> <p><i>Administer the anaphylaxis protocol for adverse reactions</i></p>
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Provider signature: _____

NPI # _____ Phone _____ Fax _____

Office Address: _____ City: _____ St _____ Zip: _____

Printed MD Name: _____ Contact Name: _____

Demographic information Patient Ins. Card H & P Office notes Failed therapies in documentation
 Up to date medication list