InfuCare Rx

Vyepti Referral Form

of Pages Faxed:_____
Fax Referral To: 877-828-3941
Phone: 877-828-3940

Date Required:_____ Ship To: ☐ Patient ☐ MD Office ☐ Other:_____

PATIENT INFORMATION

Patient Name:_____
Address:_____
City, State, Zip:_____
Home Phone:_____
Cell Phone:_____
Date of Birth:_____ ☐ Male ☐ Female
Emergency Contact:_____ Phone:_____

PRESCRIBER INFORMATION

Prescriber Name:_____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____
DEA #:_____ NPI #:_____
Contact Person:_____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance:_____ ID:_____ Group:_____
Secondary Insurance:_____ ID:_____ Group:_____
Prescription Card:_____ ID: BIN:_____ PCN:_____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS/CLINICAL INFORMATION

Primary Diagnosis:

☐ G43.7 Chronic Migraine without Aura
☐ G43.70 Chronic Migraine without Aura, not Intractable
☐ G43.71 Chronic Migraine without Aura, Intractable
☐ Other ICD-10:_____

Average number of migraine days/month over the past 3 months:_____
Date of Diagnosis:_____
List of previous migraine medication taken:_____

Therapy: ☐ New ☐ Reauthorization ☐ Restart
Date of last infusion with Vyepti:_____ Next dose due:_____
Patient Weight:_____ ☐ kg ☐ lbs Height:_____ ☐ cm ☐ in
Allergies:_____
Comorbidities:_____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity/Refills:
☐ Vyepti™ (eptinezumab-jjmr)	☐ 100mg dose (1-100mg vial) ☐ 300mg dose (3-100mg vials)	☐ Administer the diluted Vyepti solution by IV with a 0.2 or 0.22 µm in-line or add-on sterile filter. Infuse over approximately 30 minutes. Flush the line with 20 mL of 0.9% of Sodium Chloride Injection, USP. Repeat dose every 3 months.	Dispense: ☐ 1 vial (100mg) ☐ 3 vials (300mg) Refills:_____

PREMEDICATION ORDERS/OTHER MEDICATIONS

Pre-Medications & Other Medications

☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
☐ Other:_____
☐ Labs to be drawn:_____ Frequency:_____

ADDITIONAL COMMENTS:

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

X_____
DISPENSE AS WRITTEN (Date)