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	Prescriber
Patient Name:	Prescriber Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone:	Phone:
Cell Phone:	Fax:
Date of Birth: ☐ Male ☐ Female	DEA #: NPI #:
Emergency Contact: Phone:	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:

- ☐ G43.701 Chronic, W/O Aura, Not Intractable, W Status
- ☐ G43.709 Chronic, W/O Aura, Not Intractable, W/O Status
- ☐ G43.711 Chronic, W/O Aura, Intractable, W/ Status
- ☐ G43.719 Chronic, W/O Aura, Intractable, W/O Status
- ☐ G43.101 Chronic, W/Aura, Not Intractable, W/ Status
- ☐ G43.109 Chronic, W/Aura, Not Intractable, W/O Status
- ☐ G43.111 Chronic, W/Aura, Intractable, W/O Status
- ☐ G43.119 Chronic W/Aura, Intractable, W/ Status
- ☐ G43.901 Episodic, Not Intractable, W/ Status
- ☐ G43.909 Episodic, Not Intractable, W/O Status
- ☐ G43.911 Episodic, Intractable, W/ Status
- ☐ G43.919 Episodic, Intractable, W/O Status
- ☐ Other ICD-10: __________

Therapy: ☐ New ☐ Reauthorization ☐ Restart
Date of last infusion with Vyepti:__________ Next dose due:__________
Patient Weight:_____ ☐ kg ☐ lbs Height:_____ ☐ cm ☐ in
Allergies: __________
Comorbidities: __________
Avg number of headache days per month over the past 3 months:_____
Avg number of migraine days per month over the past 3 months:_____
Date of Diagnosis: __________
List of previous migraine medication taken: __________

☐ Patient using as monoclonal therapy:
If not, why?: __________

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)

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