InfuCare Rx

Vyepti™ Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940

✂ Please cut along the dotted lines before submitting to a pharmacy.

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

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
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:

☐ G43.701 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

Premedications & 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)