

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

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

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Date of Birth: _____ Gender: _____	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:	Therapy: New Reauthorization Restart
G43.701 Chronic, W/O Aura, Not Intractable, W Status	Date of last infusion with Vyepti: _____ Next dose due: _____
G43.709 Chronic, W/O Aura, Not Intractable, W/O Status	Patient Weight: _____ kg lbs Height: _____ cm in
G43.711 Chronic, W/O Aura, Intractable, W/ Status	Allergies: _____
G43.719 Chronic, W/O Aura, Intractable, W/O Status	Comorbidities: _____
G43.101 Chronic, W/Aura, Not Intractable, W/ Status	Avg number of headache days per month over the past 3 months: _____
G43.109 Chronic, W/Aura, Not Intractable, W/O Status	Avg number of migraine days per month over the past 3 months: _____
G43.111 Chronic, W/Aura, Intractable, W/O Status	Date of Diagnosis: _____
G43.119 Chronic W/Aura, Intractable, W/ Status	List of previous migraine medication taken: _____
G43.901 Episodic, Not Intractable, W/ Status	_____
G43.909 Episodic, Not Intractable, W/O Status	Patient using as monoclonal therapy:
G43.911 Episodic, Intractable, W/ Status	If not, why?: _____
G43.919 Episodic, Intractable, W/O Status	_____
Other ICD-10: _____	_____

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: _____
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ADDITIONAL COMMENTS:

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

X _____
DISPENSE AS WRITTEN (Date)