

Eptinezumab-jjmr (Vyepti)

Provider Order Form rev. 10/30/2023



PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____

Patient Address: _____ Patient Email: _____

Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____

Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Migraine: _____

Other: _____ Description: _____

THERAPY ADMINISTRATION & DOSING (Choose one)

Administer eptinezumab-jjmr (Vyepti) 100 mg IV in 100 mL NS over a period of 30 minutes. Flush with 20 ml NS following infusion.

Administer eptinezumab-jjmr (Vyepti) 300mg intravenously in 100 mL NS over a period of 30 minutes. Flush with 20 mL NS following infusion.

FREQUENCY (Choose one)

- Every 3 months
 Other _____

ADDITIONAL ORDERS

LABORATORY ORDERS

- CBC at each dose every: _____
 CMP at each dose every: _____
 CRP at each dose every: _____
 Other: _____

PRE-MEDICATION ORDERS

- Tylenol 500mg / 650mg PO
 Loratadine 10mg PO
 Pepcid 20mg PO / IVP
 Benadryl 25mg / 50mg PO / IVP
 Solumedrol 40mg / 125mg IVP
 Other: _____

NURSING

- Hold infusion and notify provider for:
- Abnormal vital signs, history of hypersensitivity to VYEPTI
 - Chance of pregnancy
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications including antiepileptic, beta blockers, Botox, Antidepressants, CGRPs, Aimovig, Emgaltiy, Triptans and Calcium channel blockers, Number of Migraines per month

Required Labs: CRP/ESR

Provider Name (print) _____

Provider Signature _____

Date _____

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.