

## PATIENT DEMOGRAPHIC INFORMATION

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_  
 Allergies See List NKDA City, State, Zip: \_\_\_\_\_  
 Weight: \_\_\_\_\_ kg lbs Height: \_\_\_\_\_ in cm Email: \_\_\_\_\_

## PRIMARY DIAGNOSIS

Migraine w/o aura, not intractable, w/o status migrainosus (G43.009)  
 Chronic migraine w/o aura, not intractable, w/o status migrainosus (G43.709)  
 Chronic migraine w/o aura, intractable, with status migrainosus (G43.711)  
 Chronic migraine w/o aura, intractable, w/o status migrainosus (G43.719)  
 Other: \_\_\_\_\_

## PRESCRIPTION

### Vyepti (eptinezumab-jjmr)

Vyepti 100mg IV every 3 months  
 Vyepti 300mg IV every 3 months  
 Other: \_\_\_\_\_

Has patient received any doses of this medication in the past? Yes No

Refill x 12 months unless otherwise noted: \_\_\_\_\_

## REQUIRED DOCUMENTATION

- Insurance Card
- Medication List
- # of Headache Days in Last Month: \_\_\_\_\_
- H&P
- Most recent labs
- # of Migraine Days in Last Month: \_\_\_\_\_
- Patient Demographics
- Tried/Failed Therapies

## ANCILLARY ORDERS

### ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol. (See [aiscargroup.com](http://aiscargroup.com) for detailed policy)

Other: Please fax other reaction orders if checking this box

### PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol: No recommended standard pre-meds for Vyepti  
 Provider Prescribed: \_\_\_\_\_

### LINE CARE ORDERS

Start PIV/Access CVC Flush device per Advanced Infusion Care Centers' protocol (See [aiscargroup.com](http://aiscargroup.com) for detailed policy)  
 Other Flush Orders: Please fax other line care orders if checking this box

### LAB ORDERS—PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 NPI: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Office Contact Person: \_\_\_\_\_ Email: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.