

Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076



ORDER FORM VYEPTI™ (eptinezumab-jjmr)

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION

Physician Name*:	Practice Name:
Address:	Office Contact*:
Phone: Fax:	Email (for updates):

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

VYEPTI ORDER*:

ICD-10*: _____

Dosing: _____ 100mg IV every 3 months
_____ 300mg IV every 3 months

Physician Signature _____

Date (Order is Valid for One Year) _____

Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

_____ Migraine
_____ Chronic Migraine w/o Aura
_____ Chronic Migraine w/o Aura Intractable
_____ Other Migraine
_____ Menstrual Migraine, Not Intractable
_____ Migraine Unspecified
_____ Migraine Unspecified Intractable
_____ Other _____

Last Infusion/Injection Date: _____

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting DX
_____ Current Medication List and H&P

STANDING LAB ORDERS: _____ CMP _____ CBC Frequency _____

NOTES/ADDITIONAL COMMENTS: ☐ Other _____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____