

Los Angeles, CA
2080 Century Park East
Suite 710
Los Angeles, CA 90067



ORDER FORM VYEPTI™ (eptinezumab-jjmr)

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
Allergies:	Date of Referral:	

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

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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) _____
<i>Infusion will be administered per MPP policy and protocols</i>	

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: <input type="checkbox"/> Other _____

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____