

Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Crown Heights
555 Lefferts Avenue
Brooklyn, NY 11225

Manhattan
57W 57Street
Suite 601
New York, NY 10019

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

Elmsford/ Terrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

NYC Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Woodbury
75 Froehlich Farm
Woodbury, NY 11797

Staten Island
27 New Dorp Lane
Staten Island, NY 10306



Manhattan
225 E 70th Street
Suite 1E
New York, NY 10021

Queens
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Manhattan
225 East 70th Street
New York, NY 10021

Holbrook/ Ronkonkoma
233 Union Ave
Suite 207
Holbrook, NY 11741

Scarsdale
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

5 Towns
141 Washington Avenue
Cedarhurst, NY 11559

Long Beach
917 Beech Street
Long Beach, NY 11561

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Bronx
226 West 238th Street
Bronx, NY 10463

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*:

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

ICD-10*: _____

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 _____