Vermont
28 Park Ave
Suite #1A
Williston, VT 05495

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

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 _____