

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



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*:

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

ICD-10*: _____

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 _____