

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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*: _____

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 _____