



Vyepti Order Form

Patient Name: _____ DOB: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Sex: _____ Height: _____ Weight: _____ Allergies: _____

DIAGNOSIS:

- Chronic Migraines ICD-10: _____
- Episodic Migraines ICD-10: _____
- Other _____ ICD-10: _____

ORDER FOR VYEPTI (EPTINEZUMAB-JJMR):

- 100mg IV every 3 months x 1 year
- 300mg IV every 3 months x 1 year
- Other Dose: _____ Frequency: _____ x 1 year

PRE-MEDICATIONS:

- Acetaminophen 650mg PO
- Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- Nevada Infusion Hypersensitivity Reaction Order Set
- Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line

FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml

NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____

Physician Signature: _____ Date: _____

Point of Contact: _____ Phone: _____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **



Patient Name: _____ DOB: _____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- Signed provider orders (page 1)
- Patient demographic and insurance information
- Patient's current medication list
- Supporting recent clinical notes and H&P (to support primary diagnosis)
- Supporting documentation to include past tried and/or failed therapies
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Has the patient had a documented contraindication/intolerance or failed trial of prophylactic migraine therapy?

Yes OR No

If yes, which drug(s)? _____

Amitriptyline Beta blocker Divalproex Topiramate

Venlafaxine Other: _____

Has the patient had a documented contraindication/intolerance or failed trial of a calcitonin gene-related peptide receptor?

If yes, please indicate drug:

Aimovig Emgality Ajovy Other: _____

Chronic Migraine: does the patient have greater than or equal to 15 headache days/ month; OR greater than or equal to 8 migraine days per month?

Yes OR No

If yes, how many? _____

Episodic Migraine: does the patient have less than 15 headache days per month; OR patient has 4-14 migraine days per month?

Yes OR No

If yes, how many? _____

Include labs and/or test results to support diagnosis - Please attach

Other medical necessity: _____

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