Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

| Referral Status: | | MRN: |
|---|---|---|
| ☐ New referral | ☐ Order change | ☐ Order Renewal |
| Patient preferred clinic: | | |

# Vyepti™ (eptinezumab-jjmr) Standard Plan of Treatment

## PATIENT DEMOGRAPHICS:

| Date of Referral: | | | Patient's Phone: | | |
|---|---|---|---|---|---|
| Patient Name: | | | Address: | | |
| Date of Birth: | | | City, State, Zip: | | |
| Height in inches: | Weight: LB or KG | | Gender: | Allergies: | ☐ See list ☐ NDKA |

## DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING )

| | |
|---|---|
| ☐ | G43. ______ - Migraine in adults |
| ☐ | ________ - Other: |

## REQUESTED DOCUMENTATION:

| | |
|---|---|
| 1 | Insurance information |
| 2 | Most recent History & Physical |
| 3 | Full medication list |
| 4 | Tried and failed therapies |
| 5 | |
| 6 | |

## PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

| IF NO: | IF YES: |
|---|---|
| PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY: | LAST INFUSION DATE: |
| | NEXT INFUSION DATE: |
| | **IF ORDER CHANGE:** |
| | ☐ **Continue current order until insurance approved** |

## MEDICATION ORDERS:

**NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans**

## DOSE/FREQUENCY:

☐ Vyepti 100mg diluted in 100ml NS every 3 months administered IV over 30 minutes

☐ Vyepti 300mg diluted in 100ml NS every 3 months administered IV over 30 minutes

**After completion of infusion, flush line with 20ml of NS**

## SPECIAL ORDERS:

☐ ________________________________________________

☑ Refills x 12 months unless noted otherwise here:

## LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

## ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

## PRESCRIBER INFORMATION:

| PROVIDER NAME: | PHONE: |
|---|---|
| ADDRESS: | FAX: |
| CITY, STATE, ZIP: | NPI: |

## PRESCRIBER SIGNATURE: (No stamp signatures) — DATE

| | | |
|---|---|---|
| Dispense as written/Brand medically necessary | Substitution permitted | |