VYEPTI (EPTINEZUMAB-JJMR)
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: ____________ **DOB:** ____________ **Phone:** ____________

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** ____________

Medical Information

Diagnosis: Chronic migraines Episodic migraines Other: ____________

ICD-10 Code: ____________

Patient Weight: ____________ lbs. (required) **Allergies:** ____________

Therapy Order

Vyepti

100 mg IV every 3 months

300 mg IV every 3 months

Refill for: 6 months 1 year Other: ____________

Other orders: ____________

Lab Orders: ____________ **Frequency:** Every infusion Other: ____________

Required labs to be drawn by: Hy-Vee Health Referring Provider

Anaphylactic reaction orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: ____________ **Signature:** ____________ **Date:** ____________

Provider NPI: ____________ **Phone:** ____________ **Fax:** ____________ **Contact Person:** ____________

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): ____________

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX

Phoenix, AZ Other ____________

HY-VEEHEALTHINFUSION.COM

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COMPREHENSIVE SUPPORT FOR VYEPTI THERAPY

Patient Information

Patient Name: ______________________ **DOB:** ______________________

Required Documentation for Referral Processing & Insurance Approval

Include signed and completed order (MD/prescriber to complete page 1)

Include patient demographic information and insurance information

Include patient's current medication list

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 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 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 No

If yes, how many? ______________________

Include labs and/or test results to support diagnosis (if applicable)

Other medical necessity: ______________________

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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