Hy-Vee health INFUSION CARE

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 ofprophylactic 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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