Eptinezumab-jjmr (Vyepti)

Provider Order Form rev. 1/23/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐ G43. ____: Migraine

☐ Other: Description:

THERAPY ADMINISTRATION & DOSING *(Choose one)*

☐ Administer eptinezumab-jjmr (Vyepti) 100 mg IV in 100 mL NS over a period of 30 minutes. Flush with 20 ml NS following infusion.

☐ Administer eptinezumab-jjmr (Vyepti) 300mg intravenously in 100 mL NS over a period of 30 minutes. Flush with 20 mL NS following infusion.

FREQUENCY *(Choose one)*

☐ Every 3 months

☐ Other _____

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every: _____

☐ CMP ☐ at each dose ☐ every: _____

☐ CRP ☐ at each dose ☐ every: _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Abnormal vital signs, history of hypersensitivity to VYEPTI
- Chance of pregnancy

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications including antiepileptic, beta blockers, Botox, Antidepressants, CGRPs, Aimovig, Emgality, Triptans and Calcium channel blockers, Number of Migraines per month

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.