INTRAMED Plus
infusion services

VYEPTI®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Migraine Headaches ICD-10 Code: G43._____

_____ Other:_____ ICD-10 Code: _____

Allergies:_____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
  - Disease history including previous treatments and outcomes
  - Any available testing results or information

Patient
Weight: _____ lbs.
Height:_____ in.

VYEPTI® (eptinezumab-jjmr)

4. Drug Order:

❑ Administer Vyepti 100 mg IV over approximately 30 minutes every 3 months

_____#Refills (Recommend 3)

❑ Administer Vyepti 300 mg IV over approximately 30 minutes every 3 months

_____#Refills (Recommend 3)

Pre-Medication Orders: _____

No pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	COLUMBIA CHARLESTON GREENVILLE
ALTERNATE FAX 803.999.1887	CENTRAL INTAKE PHONE 800.767.6337