

**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

<b>Patient</b>	
<b>Weight:</b>	_____ lbs.
<b>Height:</b>	_____ 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 #: \_\_\_\_\_

<b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b>	<b>INFUSION CENTER LOCATIONS</b> <b>COLUMBIA CHARLESTON GREENVILLE</b> <b>CENTRAL INTAKE PHONE 803.999.1760</b>
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