



PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____
 Phone Number: _____ Email Address: _____
 Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____
 Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Migraine Headaches
 _____ Other: _____

Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, Disease history including previous treatments and outcomes, Any available testing results or information 4. Recent Lab Results

Physician Information

Prescribing Physician: _____ Practice Name: _____
 Practice Phone: _____ Practice Fax: _____
 Email: _____ Office Contact: _____
 Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: VYEPTI® (eptinezumab-jjmr)

New Start: _____ # Refills (Recommend 3 Refills)
 Administer Vyepsti 100 mg IV over approximately 30 minutes every 3 months

Administer Vyepsti 300 mg IV over approximately 30 minutes every 3 months
 _____ # Refills (Recommend 3 Refills)

Pre-Medication Orders:

No pre-medications are recommended based on manufacturer guidelines.

Other: _____

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

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)
 By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

 Physician's NPI# Physician's Address

 Prescriber's Signature Date