

**Site of Care**

- ☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

VYEPTI (EPTINEZUMAB-JJMR) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Mobile Number: _____

Patient Weight: _____ Patient Height: _____ Allergies: _____

Other Medications: _____

DIAGNOSIS (Provider must specify)

☐ Migraine, ICD10: _____

☐ Other: _____

Prior to treatment – ensure the following information is complete and attached with referral:

☐ Demographics

☐ Labs and tests supporting diagnosis

☐ Office/progress notes

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Benadryl 25mg PO ☐ Methylprednisolone(Solu-Medrol) _____ mg IVP

☐ Other: _____ Dose: _____ Route: _____

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MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Vyepti	☐ 100 mg ☐ 300 mg	IV	Every 3 months

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS/SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____ Contact: _____

Phone: _____ Fax: _____ Email Address: _____

Signature: _____ Date: _____