

**Richmond**  
7110 Forest Ave, Suite 203  
Richmond, VA 23226



**Prince George**  
2025 Waterside Rd, Suite 100B  
Prince George, VA 23875

**Physician Order - Vyepti (eptinezumab-jjmr)**

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose/Frequency Change <input type="checkbox"/> Order Renewal

Location Preference (optional)	
<input type="checkbox"/> Richmond	<input type="checkbox"/> Prince George

\* \* If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required \* \*

DIAGNOSIS AND ICD-10 CODE	
Clinical Diagnosis:	ICD 10 code for given diagnosis:
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____

REQUIRED DOCUMENTATION (must include)	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information	<input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> Medication will NOT be used in combination with another biologic CGRP antagonist or inhibitor	<input type="checkbox"/> Documented chronic migraines
<input type="checkbox"/> Patient currently receiving same therapy at _____ Last dose: _____	
List Tried & Failed Therapies, including duration of treatment	
1) _____	3) _____
2) _____	4) _____

MEDICATION ORDERS	
Dosing	<input type="checkbox"/> Vyepti 100mg infuse IV over 30 minutes once every 3 months
	<input type="checkbox"/> Vyepti 300mg infuse IV over 30 minutes once every 3 months
Duration:	<input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> doses _____

OPTIONAL PREMEDICATIONS and LAB ORDERS	
<input type="checkbox"/> Acetaminophen 650mg PO prior to infusion	
<input type="checkbox"/> Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion	
<input type="checkbox"/> Methylprednisolone 40mg slow IVP prior to infusion	
<input type="checkbox"/> Other PreMed or Lab Order with frequency: _____	

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:	Date:	

**Contact us with questions at: 804-442-3558 or email [referrals@theinfusionsolution.com](mailto:referrals@theinfusionsolution.com)**

Fax completed form and ALL required documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.