Vyepti® Provider Order Form

Please fax completed referral order form & all required documents to **281-295-4051**

AguaVivir
www.aguavivir.com

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

***ICD 10 Code Required**

☐ Migraine without aura (G43.00-G43.019), ICD10 _____
☐ Migraine with aura (G43.10-G43.119), ICD10 _____
☐ Chronic migraine without aura (G43.70-G43.719), ICD10 _____
☐ Other migraine (G43.80-G43.839), ICD10 _____
☐ Migraine, unspecified (G43.90-G43.919), ICD10 _____
☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Vyepti® (eptinezumab)	☐ 100mg ☐ 300mg	Infuse IV over 30 minutes once every 3 months x 1 year

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP
☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician
☐ No labs ordered at this time
☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____
☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

☐ **See Attached Medical Records**

☐ Yes ☐ No Is Vyepti used for migraine prophylaxis?
☐ Yes ☐ No Does the patient have episodic or chronic migraine diagnosis as evidenced by the following over the last 3 months:

☐ Episodic Migraine
- Average Number of Migraine Days Per Month: _____
- Average Number of Headaches Per Month: _____

☐ Chronic Migraine
- Average Number of Migraine Days Per Month: _____
- Average Number of Headaches Per Month: _____

PRIOR FAILED THERAPIES (including antidepressant, beta-blocker, anti-epileptic, anti-hypertensive, and botulinum toxin)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
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