

# Eptinezumab-jjmr (Vyepti)

Provider Order Form rev. 1/23/2025

## PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name:	DOB:	Patient Phone:
Patient Address:	Patient Email:	
Allergies:	<input type="checkbox"/> NKDA	Weight (lbs/kg): Height (in/cm):
Sex: <input type="checkbox"/> M / <input type="checkbox"/> F	Date of Last Infusion:	Next Due Date: Preferred Location:

## DIAGNOSIS (Please provide ICD-10 code in space provided)

<input type="checkbox"/> G43. ____: Migraine	
<input type="checkbox"/> Other:	Description:

## THERAPY ADMINISTRATION & DOSING (Choose one)

- ☐ Administer eptinezumab-jjmr (Vyepti) 100 mg IV in 100 mL NS over a period of 30 minutes. Flush with 20 mL NS following infusion.
- ☐ Administer eptinezumab-jjmr (Vyepti) 300mg intravenously in 100 mL NS over a period of 30 minutes. Flush with 20 mL NS following infusion.

## FREQUENCY (Choose one)

- ☐ Every 3 months
- ☐ Other \_\_\_\_\_

## ADDITIONAL ORDERS

## LABORATORY ORDERS

- |                                       |                                       |                                       |
|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> CBC          | <input type="checkbox"/> at each dose | <input type="checkbox"/> every: _____ |
| <input type="checkbox"/> CMP          | <input type="checkbox"/> at each dose | <input type="checkbox"/> every: _____ |
| <input type="checkbox"/> CRP          | <input type="checkbox"/> at each dose | <input type="checkbox"/> every: _____ |
| <input type="checkbox"/> Other: _____ |                                       |                                       |

## PRE-MEDICATION ORDERS

- ☐ Tylenol ☐ 500mg / ☐ 650mg PO
- ☐ Loratadine 10mg PO
- ☐ Pepcid 20mg ☐ PO / ☐ IVP
- ☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
- ☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
- ☐ Other: \_\_\_\_\_

## NURSING

- ☒ Hold infusion and notify provider for:
- Abnormal vital signs, history of hypersensitivity to VYEPTI
  - Chance of pregnancy
- ☒ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

## PROVIDER INFORMATION

Preferred Contact Name:	Preferred Contact Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

## REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

**Required Documentation:** Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications including antiepileptic, beta blockers, Botox, Antidepressants, CGRPs, Aimovig, Emgality, Triptans and Calcium channel blockers, Number of Migraines per month

Provider Name (print)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.