

VYEPTI® (EPTINEZUMAB-JJMR) PRESCRIBER ORDER FORM

Patient Name: _____	Date of Birth: _____	Gender: _____
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Address: _____

Phone: _____	Height: _____	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: _____	<input type="checkbox"/> lbs <input type="checkbox"/> kg
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Clinical Information

Primary Diagnosis Description: _____	ICD-10 Code: _____
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Allergies: NKDA OR (List): _____

Medications previously tried and failed (list medication and duration of use): _____	Has patient received Botox®? <input type="checkbox"/> Yes, # of injections _____ <input type="checkbox"/> No
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Site of Infusion:

Option Care Health Infusion Services

Prescriber office or Infusion clinic: (Option Care supplies Vyepiti for delivery and administration at office/clinic)

Name of Location: _____ Address: _____

Contact name and phone for delivery coordination: _____

Prescription

For existing Vyepiti patients: Date of last infusion: _____

Vyepiti® (Eptinezumab-jjmr) refill as directed x 1 year

Infuse 100 mg IV over 30 minutes once every 3 months

Infuse 300 mg IV over 30 minutes once every 3 months

Using a 50ml 0.9% Sodium Chloride IV bag, flush IV tubing with NS 10 to 20 mL after each infusion

Infuse via a 0.2 micron in-line filter

Dispense quantity sufficient of Vyepiti® 100 mg single dose vials for each dose

Ancillary Orders

Anaphylaxis Kit

Does this patient require an anaphylaxis kit?

Yes, with 1st dose Yes, with all doses

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Pre-Medication Orders

Other: _____

IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.
Heparin (100 unit/mL) 3 to 5 mL post-use.
For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Other: _____

Lab Orders

No labs ordered at this time.

Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above.

Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name: _____	Phone: _____	Fax: _____
Address: _____	NPI: _____	
City, State: _____	Zip: _____	Office Contact: _____

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

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