

**VYEPTI® (EPTINEZUMAB-JJMR) PRESCRIBER ORDER FORM**

|                            |                             |                      |
|----------------------------|-----------------------------|----------------------|
| <b>Patient Name:</b> _____ | <b>Date of Birth:</b> _____ | <b>Gender:</b> _____ |
|----------------------------|-----------------------------|----------------------|

**Address:** \_\_\_\_\_

|                     |                      |   |                      |  |
|---------------------|----------------------|---|----------------------|--|
| <b>Phone:</b> _____ | <b>Height:</b> _____ | <input type="checkbox"/> inches <input type="checkbox"/> cm | <b>Weight:</b> _____ | <input type="checkbox"/> lbs <input type="checkbox"/> kg |
|---------------------|----------------------|---|----------------------|--|

**Clinical Information**

|   |                           |
|---|---------------------------|
| <b>Primary Diagnosis Description:</b> _____ | <b>ICD-10 Code:</b> _____ |
|---|---------------------------|

**Allergies:**  NKDA OR (List): \_\_\_\_\_

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

**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 1<sup>st</sup> 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**

|                               |                     |                              |
|-------------------------------|---------------------|------------------------------|
| <b>Prescriber Name:</b> _____ | <b>Phone:</b> _____ | <b>Fax:</b> _____            |
| <b>Address:</b> _____         | <b>NPI:</b> _____   |                              |
| <b>City, State:</b> _____     | <b>Zip:</b> _____   | <b>Office Contact:</b> _____ |

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

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