

VYEPTI® (EPTINEZUMAB-JJMR) PRESCRIBER ORDER FORM				
Patient Name:		Date of Birth:		
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
Clinical Information				
Primary Diagnosis Description:			ICD-10 Code:	
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	
Prescription				
For existing Vyepti patients: Date of last infusion: _____ Vyepti® (Eptinezumab-jjmr) refill as directed x 1 year <input type="checkbox"/> Infuse 100 mg IV over 30 minutes once every 3 months <input type="checkbox"/> 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 Vyepti® 100 mg single dose vials for each dose				
Ancillary Orders				
Anaphylaxis Kit Does this patient require an anaphylaxis kit? <input type="checkbox"/> Yes, with 1 st dose <input type="checkbox"/> Yes, with all doses <ul style="list-style-type: none"> 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 <input type="checkbox"/> Other: _____				
IV Flush Orders <input type="checkbox"/> <u>Peripheral:</u> 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. <input type="checkbox"/> <u>Implanted Port:</u> 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. <input type="checkbox"/> <u>Other:</u>				
Lab Orders <input type="checkbox"/> No labs ordered at this time. <input type="checkbox"/> 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.				
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>				
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:				
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