Orsini
Rare Disease Pharmacy Solutions

Fax: 877-892-3019 **Phone:** 800.259.7145

VYEPTI® (eptinezumab-jjmr) ENROLLMENT FORM

1 PATIENT INFORMATION *(Please complete the following information)*

Patient Name (First, MI, Last): ______ DOB: ______ Gender: Male Female

Address: ______ City: ______ State: ______ Zip: ______

Patient Phone Number: ______

2 PATIENT INSURANCE INFORMATION **Please provide a copy of patient's MEDICAL and PRESCRIPTION cards**

Primary Insurance Name: ______ Insurance Phone Number: ______

Primary Insurance ID: ______ Policyholder Name: ______

3 MEDICAL ASSESSMENT **Please fax clinical documentation to pharmacy along with referral form.**

Patient Height: ______ Patient Weight: ______ Allergies: ______

Diagnosis (ICD-10 Code): ______ Date Migraines started: ______ Number of headache days per month: ______

Previous Acute Migraine Medication *(last 3 months)*:

Name of drug and dose	Duration of therapy	Outcome (effective, suboptimal, intolerant, failed)	Discontinued (Y/N) - Reason?

Previous Prophylactic Migraine Medication *(last 3 months)*:

Name of drug and dose	Duration of therapy	Outcome (effective, suboptimal, intolerant, failed)	Discontinued (Y/N) - Reason?

4 PRESCRIBER INFORMATION

Practice Name: ______

Prescriber Name: ______ Specialty: ______ NPI: ______

Practice Address: ______ City: ______ State: ______ Zip: ______

Office Contact: ______ Phone: ______

Fax: ______ Email: ______

5 SITE OF INFUSION

Please choose one: Office Infusion Clinic

If Infusion Clinic, please fill out below:

Infusion Clinic Name: ______

Address: ______ City: ______ State: ______ Zip: ______

Infusion Clinic Contact Name: ______ Phone: ______ Email: ______

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6 VYEPTI PRESCRIBING INFORMATION

VYEPTI PRESCRIPTION

Drug: VYEPTI 100-mg/mL single-use vial | **SIG:** Infuse_____ mg over 30 min once every 3 months | **Qty:** ____(vials) _____ Refills:

(Recommended dose is 100mg IV every 3 months. Some patients may benefit from Vyepti 300mg IV every 3 months. Supplied as Vyepti 100mg/ml – 1 ml vial)

7 PHYSICIAN SIGNATURE (Required)

X ______________________________ ____________

PRODUCT SUBSTITUTION PERMITTED Date of Signature

X ______________________________ ____________

DISPENSE AS WRITTEN Date of Signature

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

8 PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

(Signature and Date Requirement)

By signing below, I authorize my healthcare providers (including pharmacies and infusion providers) and health plans (together, my "Heath Team") to disclose my personal health information relevant to my treatment or potential treatment with VYEPTI® (eptinezumab-jjmr), including my contact and other information provided on this enrollment form (my "Information"), to Lundbeck LLC and it's affiliates, agents, representatives, and service providers (collectively, "Lundbeck"), so that Lundbeck can undertake the activities listed below that involve the use and disclosure of my information.

I authorize Lundbeck to share my information with my Health Team to communicate about my benefit and coverage status and my medical care and payments for my medical treatment, and to use my information to: (1) administer the VYEPTI Patient Support Program(s) I enroll in (collectively, the "Programs"), as applicable; (2) provide me with patient support, including facilitating the provision of VYEPTI to me; (3) provide me with information and promotional materials relating to Lundbeck products and/or my condition or treatment; (4) contact me for Program or research purposes or to provide the information about Lundbeck products and services, including by phone, email and/or text message, and including through messages that disclose that I take or may take VYEPTI; and (5) allow Lundbeck to analyze the usage patterns and the effectiveness of Lundbeck products, support, and programs and help develop new products, support, and programs, and for other Lundbeck general business and administrative purposes. I understand that Lundbeck may compensate my pharmacy providers for communicating with me about the benefits of Lundbeck products or services, and I authorize my pharmacy providers to make such communications.

I understand that I am not required to sign this Authorization in order to receive healthcare benefits or treatment, including with Lundbeck products. I also understand that once my information has been disclosed to Lundbeck, federal privacy laws may no longer restrict its disclosure and it might legally be redisclosed to others.

I understand that I may cancel this authorization at any time by sending a written cancellation notice to 1111 Nicholas BLVD, Elk Grove Village, IL 60007, attention, Privacy Office. I understand that if I were to cancel the authorization, it would be invalid for further uses and disclosures of my Information, but that my cancellation would not invalidate any uses and disclosures of my Information made prior to the Program's receipt of my notice of withdrawal. I understand that if I do not cancel this authorization, the authorization will expire ten years from the date of signature (or the maximum period allowed by applicable state laws, if less than ten years. I understand that I am entitled to receive a copy of this authorization once it has been signed.

Print Patient/Authorized Contact Name: ______________________________

Relationship to Patient: **Self** **Spouse** **Other:** ______________________________

Patient Cell Phone: ____________________ **Patient Email:** ______________________________

X ______________________________ ____________

PATIENT/AUTHORIZED CONTACT SIGNATURE DATE OF SIGNATURE