Fax: 877-892-3019 Phone: 800.259.7145

Orsini Specialty Pharmacy

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 ◯ Home

If Infusion Clinic, please fill out below:

Infusion Clinic Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Infusion Clinic Contact Name: _____ Phone: _____ Email: _____

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 Vypeti 100mg/ml – 1 ml vial)

☐ HOME INFUSION/NURSING ORDERS (please check box if patient is infusing in the home)

- **Skilled Nursing Visit: As needed for IV access, drug administration and clinical monitoring.**
- **Provide necessary infusion and flush supplies (e.g. tubing).**
- **Infusion instructions:**
  - Use 10ml NS flush to establish line patency
  - Dilute in 100ml 0.9% Sodium Chloride Inj, USP.
  - Use an infusion set with 0.2 micron or 0.22 micron in-line or add-on sterile filter.
  - After infusion, flush IV line with 20ml of 0.9% NaCl.

INFUSION REACTION MANAGEMENT ORDERS (complete these items as appropriate.)

1. **If infusion reaction occurs STOP drug infusion and start 0.9% saline 250ml- administer at 50ml/h once infusion stops**

2. **CALL PRESCRIBER at:** _____

3. **ADMINISTER EMERGENCY MEDS PER PHYSICIAN ORDERS** Quantity: 90 days Refills: 1 year

   ☐ **Diphenhydramine ____mg/ml IV push over 2 to 5 minutes for mild to moderate Infusion Reaction**

   ☐ **Epinephrine 0.3mg IM injection for severe anaphylaxis. If severe symptoms persist, may repeat Epinephrine IM in 20 minutes, if needed. Call 911.**

7 PHYSICIAN SIGNATURE (Required)

X _____ _____ X _____ _____

PRODUCT SUBSTITUTION PERMITTED | Date of Signature | DISPENSE AS WRITTEN | Date of Signature

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