

**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

PRODUCT SUBSTITUTION PERMITTED

Date of Signature

X

DISPENSE AS WRITTEN

Date of Signature

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