BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

VYEPTI (EPTINEZUMAB-JJMR)
INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: ☐ Chronic Migraines ☐ Episodic Migraines ☐ Other: _____

ICD-10 Code: _____

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Vyepti

☐ 100mg IV every 3 months

☐ 300mg IV every 3 months

Refill for: ☐ 6 months ☐ 1 year ☐ Other: _____

Other orders: _____

Lab Orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

Required labs to be drawn by: ☐ Biocare Infusion ☐ Referring Provider

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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COMPREHENSIVE SUPPORT FOR VYEPTI THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1

☐ Include patient demographic information and insurance information

☐ Include patient's current medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

☐ Has the patient had a documented contraindication/intolerance or failed trial of prophylactic migraine therapy? ☐ Yes ☐ No If yes, which drug(s):

- ☐Amitriptyline
- ☐Beta blocker
- ☐ Divalproex
- ☐Topiramate
- ☐Venlafaxine
- ☐Other: _____

☐ Has the patient had a documented contraindication/intolerance or failed trial of a calcitonin gene-related peptide receptor? If yes, please indicate drug:

☐Aimovig ☐ Emgality ☐ Ajovy ☐ Other: _____

☐ Chronic Migraine: does the patient have greater than or equal to 15 headache days/ month; OR greater than or equal to 8 migraine days per month? ☐ Yes ☐ No
If yes, how many? _____

☐ Episodic Migraine: does the patient have less than 15 headache days per month; OR patient has 4-14 migraine days per month? ☐ Yes ☐ No
If yes, how many? _____

☐ Include labs and/or test results to support diagnosis (if applicable)

☐ Other medical necessity: _____

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance