Your Health, True Wealth

Vyepti® (eptinezumab-jjmr) Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:
f: 818-882-8929

PATIENT INFORMATION

Patient Name	DOB	Contact Phone	
Address	City	State	Zip
Gender ☐M ☐F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
☐ NKDA	☐Allergies		
ICD-10 code (required)	ICD-10 description		
Patient Status ☐New to Therapy ☐Continuing Therapy, Last Dose			
Number of headache days per month	Number of migraine days per month		

PRESCRIBER INFORMATION

Ordering Prescriber Practice	Prescriber NPI		
Name	Phone	Fax	
Practice Address	City	State	Zip

REQUIRED DOCUMENTATION

☐Insurance Cards ☐Clinical Notes ☐Most Recent Labs ☐Medication List

VYEPTI TREATMENT PLAN

Forexisting Vyepti patients: Date of last infusion
Vyepti (eptinezumab-jjmr) refill as directed x 1 year

- Infuse via a 0.2-micron in-line filter
- Dispense quantity sufficient of Vyepti vials for each dose

☐Infuse100 mg IV over 30 minutes once every 3 months
☐Infuse 300 mg IV over 30 minutes once every 3 months

- Using 0.9% Sodium Chloride, flush IV tubing with NS 20 mL after each infusion

PREVIOUS MIGRAINE TREATMENTS

☐ Has the patrient had a documentedcontraindication/intolerance or failed trial of any of the following preventive migraine treatments?

If yes, please indicate drug in the discontinuation date below

- ☐ Aimovig Discontinuation Date
- ☐ Emgality Discontinuation Date
- ☐ Ajovy Discontinuation Date
- ☐ Qulipta Discontinuation Date
- ☐ Nurtec (for prevention) Discontinuation Date
- ☐ Ubrelvy (for prevention) Discontinuation Date
- ☐ Botox (# of injections) Discontinuation Date
- ☐ Other Discontinuation Date

PROPHYLACTIC MIGRAINE MEDICATION

☐ Has the patienthad adeocumented contraindiction/intolerance or failed trial of prophylactic migraine therapy?

If yes, please indicate drug(s) in the discontinuation date below

- ☐ Amitriptyline Discontinuation Date
- ☐ Beta Blocker Discontinuation Date
- ☐ Divalproex Discontinuation Date
- ☐ Topiramate Discontinuation Date
- ☐ Venlafaxine Discontinuation Date
- ☐ Other Discontinuation Date

PREMEDICATION

☐ Include premedication per Northridge Pharmacy Specialty & Infusion's infusion protocol.
☐ Other

I authorize the above patient treatment and Northridge Pharmacy Specialty & Infusion to serve as my agent when investigating and seeking approval of coverage and benefits for the Patient's services included in this form, including all site of service options and patient financial responsibility amounts. Such information may be provided to Northridge Pharmacy Specialty & Infusion at fax: 818-882-8929.

Prescriber Name (Print) _____ Prescriber Signature _____ Date _____