SOLEO HEALTH®
Simplifying Complex Care

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:
p: 844.575.1515 | f: 877.393.1616 | e: specialtyreferrals@soleohealth.com.

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		Prescriber NPI	
Practice Name		Phone	Fax
Practice Address	City	State	Zip

REQUIRED DOCUMENTATION

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

VYEPTI TREATMENT PLAN

For existing 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 documented contraindication/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 patient had a deocumented 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 Soleo's infusion protocol.

☐ Other

I authorize the above patient treatment and Soleo Health 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 Soleo Health at phone 844.575.1515, fax 844.797.5050, or email specialtyreferrals@soleohealth.com.

Prescriber Name (Print) _____ Prescriber Signature _____ Date _____