

Vyepti® (eptinezumab-ijmr) 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.

This form is not a valid prescription

✂ Please detach before submitting to a pharmacy. Cut or tear here.

PATIENT INFORMATION					
Patient Name			DOB	Contact Phone	
Address		City	State	Zip	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security, last 4 digits		Weight (lb.)	Height (in.)	
<input type="checkbox"/> NKDA	<input type="checkbox"/> Allergies			Date	
ICD-10 code (required)			ICD-10 description		
Patient Status <input type="checkbox"/> New to Therapy <input type="checkbox"/> 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					
<input type="checkbox"/> Insurance Cards	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Most Recent Labs	<input type="checkbox"/> Medication List		
VYEPTI TREATMENT PLAN					
For existing Vyepti patients: Date of last infusion					
Vyepti (eptinezumab-ijmr) refill as directed x 1 year					
<ul style="list-style-type: none"> • Infuse via a 0.2-micron in-line filter • Dispense quantity sufficient of Vyepti vials for each dose 		<input type="checkbox"/> Infuse 100 mg IV over 30 minutes once every 3 months <input type="checkbox"/> Infuse 300 mg IV over 30 minutes once every 3 months <ul style="list-style-type: none"> • Using 0.9% Sodium Chloride, flush IV tubing with NS 20 mL after each infusion 			
PREVIOUS MIGRAINE TREATMENTS			PROPHYLACTIC MIGRAINE MEDICATION		
<input type="checkbox"/> Has the patient 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			<input type="checkbox"/> Has the patient had a documented contraindication/intolerance or failed trial of prophylactic migraine therapy? If yes, please indicate drug(s) in the discontinuation date below		
<input type="checkbox"/> Aimovig	Discontinuation Date		<input type="checkbox"/> Amitriptyline	Discontinuation Date	
<input type="checkbox"/> Emgality	Discontinuation Date		<input type="checkbox"/> Beta Blocker	Discontinuation Date	
<input type="checkbox"/> Ajovy	Discontinuation Date		<input type="checkbox"/> Divalproex	Discontinuation Date	
<input type="checkbox"/> Qulipta	Discontinuation Date		<input type="checkbox"/> Topiramate	Discontinuation Date	
<input type="checkbox"/> Nurtec (for prevention)	Discontinuation Date		<input type="checkbox"/> Venlafaxine	Discontinuation Date	
<input type="checkbox"/> Ubrovelvy (for prevention)	Discontinuation Date		<input type="checkbox"/> Other	Discontinuation Date	
<input type="checkbox"/> Botox (# of injections)	Discontinuation Date				
<input type="checkbox"/> Other	Discontinuation Date				
PREMEDICATION					
<input type="checkbox"/> Include premedication per Pharmacy's infusion protocol.					
<input type="checkbox"/> Other					

The Pharmacy may contact the prescriber to comply with state-specific requirements. The prescriber is required to comply with any applicable state-specific prescription requirements (e.g., e-prescribing, prescription forms).

The information in this form is intended only for the person(s) or entity to which it is addressed and may contain confidential or legally protected material. If you receive this information in error, please contact the sender and destroy the document(s) promptly at the direction of the sender.