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.
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 ☐ M ☐ F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
☐ NKDA	☐ Allergies		Date
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	☐ History & Physical	☐ 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 Pharmacy's infusion protocol.

☐ 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).