

Vyepti Referral Form

****Please Attach Copy of Insurance Cards (Front & Back)****

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip:	Sex: M F
City:	State:	Zip:	
Phone:	SSN#	Prescriber Name:	
Insurance Information			Prescriber NPI:
Insurance Plan:	Insurance Plan:	Nurse/Key Contact:	
Policy #	Policy #	Phone:	
Plan I.D. #	Plan I.D. #	Fax:	Email:

Diagnosis & Clinical Information

****Please Attach Clinical/Progress Notes, Labs, Test, Supporting Primary Diagnosis****

Chronic Migraines Episodic Migraines Allergies: _____
 Other: _____ ICD-10 Code: _____
 Currently received and/or prior failed therapies: _____
 Length of treatment: _____
 Reason for discontinuation: _____
 Height: _____ Weight: _____
 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? 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? _____ Yes No If yes, how many? _____
 Clinical Notes: _____

THERAPY ORDER

Vyepti 100mg IV every 3 months Refill for: 6 months 1 year Other: _____
 300mg IV every 3 months Other orders: _____
 Lab Orders: _____ Frequency: Every infusion Other: _____
 Required labs to be drawn by: Referring Provider Other: _____
Anaphylaxis Protocol: **Flushing Protocol:**
 PER Pharmacy Protocol PER Pharmacy Protocol
 PER Prescriber Protocol: _____ PER Prescriber Protocol: _____

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____
Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.