vitalcare® INFUSION SERVICES

Pharmacy Name: Vital Care Specialty
Address: 1501 23rd Ave. Suite B
City/State/Zip: Meridian, MS, 39301

Phone: 877-229-1724
Fax: 877-229-1725
Email: info@vitalcarerx.com

# Vyepti Referral Form

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

| | | | | | |
|---|---|---|---|---|---|
| **Last Name:** | First Name: | | DOB: | Practice: | |
| Address: | | | | Address: | |
| City: | State: | Zip: | Sex: ☐ M ☐ | 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

☐ Other:_____ ICD-10 Code:_____

Currently received and/or prior failed therapies:_____

_____

Length of treatment: _____

Reason for discontinuation:_____

Height:_____ Weight:_____

Allergies: _____

_____

_____

Clinical Notes:_____

_____

_____

_____

_____

☐ 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?

☐ Yes ☐ No If yes, how many?_____

☐ 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?_____

## THERAPY ORDER

**Vyepti** 100mg IV every 3 months

300mg IV every 3 months

Refill for: ☐ 6 months ☐ 1 year ☐ Other: _____

Other orders: _____

Lab Orders: _____ Frequency: ☐ Every infusion ☐ Other: _____

Required labs to be drawn by: ☐ Referring Provider ☐ Other:_____

**Anaphylaxis Protocol:**

☐ PER Pharmacy Protocol

☐ PER Prescriber Protocol: _____

**Flushing Protocol:**

☐ PER Pharmacy 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**