

## 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:	
<b>Insurance Information</b>			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? \_\_\_\_\_

## 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.