



VYEPTI MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ Patient's weight in pounds _____

■ Diagnosis *Please write in the patient's diagnosis and most specific ICD-10 code.*

G43. _____

■ Details Needed for Approval

- For chronic migraines, how many migraine-like or tension-like headaches does the patient have per month? _____
- For episodic migraines:
 - How many migraines per month? _____
 - How long do the headaches usually last? _____
 - Do the migraines significantly diminish the patient's quality of life? _____
 - Has the patient failed on, or have contraindications to, 2 or more therapies? _____ Which ones? _____
 - Without Vyepti, is the patient at risk of medication overuse headache? _____
- How many headache days does the patient have per month? _____
- Has medication overuse headache been ruled out? _____
- Has the patient failed on at least one migraine prophylaxis medication? _____ Which one(s)? _____
- If the patient is using Botox for prophylaxis, will they stop using it once starting Vyepti? _____ If not, why? _____
- If the patient is using any other CGRP antagonists, will they stop using it once starting Vyepti? _____ If not, why? _____

■ Medication Order

100mg by IV over 30-40 minutes every 12 weeks for 1 year.

300mg by IV over 30-40 minutes every 12 weeks for 1 year.

- Most insurers require inadequate response at 100mg before approving 300mg. Has patient had inadequate response at 100mg? _____

Vyepti is administered through 0.2 micron DEHP-free IV tubing.

■ Rescue Management in case of Infusion Therapy Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ Ordering Provider Authorization

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.