INTRAMED Plus
infusion services

VYEPTI®

INFUSION & MEDICAL CENTER

1. Patient Name ______________________ **DOB** ____________ **Patient Phone/Cell #** ____________

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Migraine Headaches ICD-10 Code: G43.________

_____ Other:______________________________ ICD-10 Code: ___________

Allergies:____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
  - Disease history including previous treatments and outcomes
  - Any available testing results or information

Patient
Weight: __________ lbs.
Height:__________ in.

VYEPTI® (eptinezumab-jjmr)

4. Drug Order:

❑ Administer Vyepti 100 mg IV over approximately 30 minutes every 3 months

_______#Refills (Recommend 3)

❑ Administer Vyepti 300 mg IV over approximately 30 minutes every 3 months

_______#Refills (Recommend 3)

Pre-Medication Orders: ____

No pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: ________________________ / ________________________ Date: ____________

Dispense as written Substitution permitted

Printed Physician's Name:_________________________________Contact Phone #: ________________

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760

JUNE 2023