



VYEPTI (EPTINEZUMAB) INFUSION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:	DOB:	Gender: ☐ Female ☐ Male	
Address:	City:	State:	ZIP:
Phone:	Email:	Height:	☐ inches ☐ cmWeight: ☐ lbs. ☐ kg
Allergies:			

Diagnosis Code ICD-10 (required):	Diagnosis Description:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy	Next Treatment Date:

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:	City:	State: ZIP:
NPI #:	DEA#:	Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Vyepti (eptinezumab)	☐ 100mg IV every 3 months ☐ 300mg IV every 3 months ☐ Other: _____	☐ x 1 year ☐ _____

Other orders: _____

Lab Orders: _____ Frequency: _____

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing LIVbetter Infusions, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X

Date:



COMPREHENSIVE SUPPORT FOR VYEPTI (EPTINEZUMAB) THERAPY

PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's current medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
 - ☐ Has the patient had a documented contraindication/intolerance or failed trial of prophylactic migraine therapy? ☐ Yes ☐ No If yes, which drug(s):
 - ☐ Amitriptyline
 - ☐ Beta blocker
 - ☐ Divalproex
 - ☐ Topiramate
 - ☐ Venlafaxine
 - ☐ Other: _____
 - ☐ 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? _____
- ☐ Include labs and/or test results to support diagnosis (if applicable)
- ☐ Other medical necessity: _____