

Infusion Order Form

Prescriber Info	Prescriber _____ NPI _____	
	Phone _____ Fax _____ Office Contact _____	
	Address _____	
Patient Info	Name _____ DOB _____ ☐ M ☐ F	
	Address _____	
	Phone _____ Primary Insurance _____	
	Insurance Policy # _____ Insurance Group # _____	
Clinical Info	Diagnosis (Include ICD 10) _____	
	Weight ____ ☐ lb ☐ kg Height ____ in Allergies _____	
	Patients first dose? ☐ Yes ☐ No (If no, date of last dose: _____)	
	Prior treatments and reason for discontinuation: _____	
	Migraine Frequency: _____	
	Average Number of Migraines per month over the past 3 months: _____	
	Additional notes: _____	
Prescription Info	Vyepti Dosing regimen: ☐ Vyepti 100mg in 100mL NaCl 0.9% ☐ Vyepti 300mg in 100mL NaCl 0.9%	Quantity: _____ doses (infusions) _____ doses (infusions)

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary.

Signature _____ Date _____