Intravene – **Vyepti Injection Orders** **(rev 4/2022)**

Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434)947-3900 ext. 3001

PATIENT INFORMATION

Name ______________________________

Address ______________________________

City ______________________________

State ____________ Zip Code ________

Home Phone # ________________________

Work Phone # ________________________

DOB _________SSN __________________

Height ___________ Weight ________lbs

Drug Allergies________________________

□ NKDA Sex: □ Male or □ Female

REFERRING PHYSICIAN INFORMATION

Physician Name ___________________________

Physician Address_________________________

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Physician Phone(_____)_____________________

Physician Fax(____)_________________________

NPI#__________________DEA#_____________

State License#_______________________________

****Please fax copies of insurance cards, clinical documents and this form to 434-455-5531****

DIAGNOSIS (ICD-10 required)

☐ ________________________________

☐ ________________________________

Date migraines started: _____________

Number headache days per month:___________

Other Acute Migraine Medication (last 3 months)

Name of Drug and dose	Duration	Outcome (effective, suboptimal (intolerant, failed)	Discontinued Y/N

Previous Prophylactic Migraine Medication (last 3 months)

Name of Drug	Class	Outcome (effective, suboptimal (intolerant, failed)	Discontinued Y/N

PRESCRIPTION:

Dispense: Vyepti ______mg IV over 30 minutes every 3 months. Flush with 20ml Normal Saline after infusion.

Duration: □ 1 year □ other_____________

ANAPHYLACTIC MEDS AND VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL

Signature, prescribing MD ________________________ Date: ________________