Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Vyepti Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Chronic Migraines ICD-10:_____
- ☐ Episodic Migraines ICD-10:_____
- ☐ Other_____ ICD-10:_____

ORDER FOR VYEPTI (EPTINEZUMAB-JJMR)

- ☐ **100mg IV every 3 months x 1 year**
- ☐ **300mg IV every 3 months x 1 year**
- ☐ **Other Dose:** _____ **Frequency:** _____ x 1 year

PRE-MEDICATIONS:

- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised: 05/2025

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)
☐ Patient demographic and insurance information
☐ Patient's current medication list
☐ Supporting recent clinical notes and H&P (to support primary diagnosis)
☐ Supporting documentation to include past tried and/or failed therapies
☐ 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 OR ☐ 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 OR ☐ 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 OR ☐ No
If yes, how many? _____

☐ Include labs and/or test results to support diagnosis - Please attach

☐ Other medical necessity: _____

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