



## Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION			
Name:	DOB:	Prescriber Name:			
Address:		State License:	State License:		
City, State, Zip:		NPI #:	NPI #: Tax ID:		
Phone: Alt. Phone:		Address:			
Email: SS#:		City, State, Zip:			
Gender:   M   F   Weight:(lbs)   Ht:			Fax:		
Allergies:		Office Contact:	Phone:		
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)					
Primary Insurance:		Secondary Insurance (If Applicable):			
Plan #:		Plan #:			
Group #:		Group #:			
RX Card (PBM):		RX Card (PBM):			
BIN: PCN:		BIN:	PCN:		
CLINICAL INFORMATION					
G43.711 Chronic migraine without aura, intractable, with status migrainosus G43.111 Migraine with aura, intractable, with status migrainosus					
☐ G43.119 Migraine with aura, intractable	e, without status migrainosus $\ \Box$ (	Other ICD-10 Code:			
Date of Diagnosis:	Average number of	migraine days over the last 3	months:		
Previous Migraine Medications:					
VYEPTI® ORDERS					
Prescription type: ☐ New start ☐ Restar	t □ Continued therapy Total D	oses Received:	Date of Last Injection/Infusion:		
Medication	Dose		Refills		
□ Vyepti (eptinezumab-jjmr)	☐ 100 mg dose (1-100mg vial)		1 vial (100mg) Refills:		
	☐ 300 mg dose (3-100mg vial)		☐ 3 vials (300mg) Refills:		
Administer the diluted Vyepti solution by IV with a 0.2 or 0.22 μm in-line or add-on sterile filter. Infuse over approximately 30 minutes. Flush the					
line with 20 mL or 0.9% Sodium Chloride Injection, USP. Repeat dose every 3 months.  ☐ Other:					
Pre-Medication	Dose/Strength		Directions		
☐ Acetaminophen	□ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed			
Diphenhydramine	☐ 25mg IV/PO	☐ Take 1 tablet PO prior to infusion or as directed OR			
	☐ 50mg IV/PO	☐ Inject contents of 1 vial IV prior to infusion or as directed			
	☐ 40mg ☐ 100mg	☐ Inject contents of 1 vial IV prior to infusion or as directed			
☐ Methylprednisolone	☐ <b>12</b> 5mg	$\square$ Other: Inject 100mg IV 30 minutes prior to infusion			
INFUSION REACTION ORDERS					
Mild reaction protocol:					
☐ Diphenhydramine 25mg IV, one time, for pruritus.					
If symptoms worsen, see orders for moderate to severe reactions.					
ij symptoms worsen, see orders jor moderd	ite to severe reactions.				

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oximes Acetaminophen 650mg PO, one time, for pyrex	ia or rigors				
$\ oxdot$ Diphenhydramine 50mg IV, one time, for prurit	tus or urticaria				
oximes Methylprednisolone 125mg IV, one time, for re	spiratory or neurologic sy	mptoms			
If symptoms worsen, see interventions for severe r	reactions				
Severe reaction protocol: (Call 911 if initiated):					
☑ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)					
oximes Diphenhydramine 50mg IV,one time, for respira	atory symptoms, edema, c	or anaphylaxis			
oximes Methylprednisolone 125mg IV, one time, for re	espiratory symptoms, eden	na, or anaphylaxis			
oximes Sodium Chloride 0.9% 500mL IV over 30-60 mir	n, one time, for cardiovasc	ular symptoms			
oxtimes Epinephrine 0.3mg/0.3mL IM into mis-anterola	teral aspect of thigh of ana	aphylaxis, may repeat x1	in 5-15 minutes if symptoms are not resolved or		
worsen					
FLUSHING & LOCKING ORDERS					
Flushing Protocol (>66lbs/33kg)					
PIV and Midline:		Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:			
☑ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion		☑ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL			
Locking Protocol (>66lbs/33kg)		IV flush after infusion/	iab draw		
PIV and Midline:	PICC:		Implanted Port, Tunneled Catheter, and Non-		
☐ Heparin Sodium 10 units/mL 1mL IV final	☐ Heparin Sodium 10 units/mL 3mL IV final		tunneled Catheter:		
flush post normal saline flush	flush post normal saline flush				
			flush post normal saline flush		
** May substitute Dextrose 5% in Water, or alternative	, for 0.9& Sodium Chloride, v	vhen indicated due to inco	mpatibility with medications bring infused		
SIGNATURE					
We hereby authorize Talis Healthcare LLC to proving medicine as prescribed in this referral.	vide all supplies and addition	onal services (nursing/pa	tient training) required to provide and deliver the		

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Signature

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Prescriber