Eptinezumab-jjmr (Vyepti)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☑ New Referral ☑ Dose or Frequency Change ☑ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy	☐ Continuing Therapy - Last Treatment Date:		Next Due Date:
PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
DIAGNOSIS AND ICD 10 CODE			
☐ ICD-10 Description:_____	ICD-10 Code: _____		
REQUIRED DOCUMENTATION/Testing			
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx			
List Tried & Failed Therapies, including duration of treatment: 1) 2)			
MEDICATION ORDERS			
☐ Vyepti 100 mg IV every 3 months			
☐ Vyepti 300 mg IV every 3 months			
Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____ **(if not indicated order will expire one year from date signed)*			

SPECIAL INSTRUCTIONS

Provider Name (Print) **Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Revised 1/27/23