Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____/_____/_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

Office Fax # (_____) _____-_____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Vyepti® (eptinezumab-jjmr) Treatment Plan

Patient Name: _____ **Patient DOB** _____/_____/_____

General

☐ Diagnosis- Migraine in adults ICD-10 Code G43._____

☐ Diagnosis- Other ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

Authorized Treatment Duration ☐ **12 Months** ☐ **Other** _____

Infusion

☑ Vital Signs (Month 1 to 12) BP/HR/Resp/SpO2/Temp
Baseline on arrival to unit, upon completion of therapy, and prior to discharge

Treatment

☐ Vyepti (eptinezumab-jjmr)
100mg, *IV Piggyback, Powder-Inj, Day of Tx- To be administered every 3 months*
Comments: Dilute in 100 mL 0.9% NaCl and administer as an intravenous infusion over 30 min. Must be administered with 0.2 or 0.22 micron in-line filter and flushed with 20ml NS

☐ Vyepti (eptinezumab-jjmr)
300mg*, IV Piggyback, Powder-Inj, Day of Tx- To be administered every 3 months*
Comments: Dilute in 100 mL 0.9% NaCl and administer as an intravenous infusion over 30 min. Must be administered with 0.2 or 0.22 micron in-line filter and flushed with 20ml NS

☑ Notify Provider
for Fever/Chills, chest pain, hypotension, hypertension, dyspnea, pruritis, urticarial, persistent flushing, Temperature > 100 or HR <50 or > 130

☑ INF Infusion Room Orders Subphase

Patient Monitoring Acknowledgement:

***** CMC Outpatient Infusion Services (OIS) does not routinely screen for pregnancy status as part of migraine infusion therapy administration. Referring provider acknowledges that for women of childbearing age, risk vs. benefit has been discussed with patient and patient is aware to notify referring provider should they become pregnant while actively receiving migraine infusion therapy.

Provider Initials_____

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____