

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

- | | |
|---|---|
| <input type="checkbox"/> G43. _____ Migraine w/o Aura | <input type="checkbox"/> G43.6 _____ Persistent Migraine Aura w/Cerebral Infarction |
| <input type="checkbox"/> G43.1 _____ Migraine w/Aura | <input type="checkbox"/> G43.61 _____ Persistent Migraine Aura w/Cerebral Infarction, Intractable |
| <input type="checkbox"/> G43.4 _____ Hemiplegic Migraine | <input type="checkbox"/> G43.7 _____ Chronic Migraine w/o Aura |
| <input type="checkbox"/> G43.41 _____ Hemiplegic Migraine, Intractable | <input type="checkbox"/> G43.71 _____ Chronic Migraine w/o Aura, Intractable |
| <input type="checkbox"/> G43.5 _____ Persistent Migraine Aura w/o Cerebral Infarction | <input type="checkbox"/> G43.8 _____ Other Migraine |
| <input type="checkbox"/> G43.51 _____ Persistent Migraine Aura w/o Cerebral Infarction, Intractable | <input type="checkbox"/> G43.81 _____ Other Migraine, Intractable |
| <input type="checkbox"/> Other: _____ | |

REQUIRED: Demographics & Most Recent: H&P, clinical notes, labs, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

PRESCRIPTION

Pre-Medications

- | | |
|---|--|
| <input type="checkbox"/> Acetaminophen: 650 mg PO | <input type="checkbox"/> Acetaminophen: _____ mg PO |
| <input type="checkbox"/> Cetirizine 10 mg PO | <input type="checkbox"/> Famotidine: 20 mg IV |
| <input type="checkbox"/> Dexamethasone: _____ mg IV | <input type="checkbox"/> Loratadine 10 mg PO |
| <input type="checkbox"/> Diphenhydramine: 25 mg PO | <input type="checkbox"/> Methylprednisolone: 125 mg IV |
| <input type="checkbox"/> Diphenhydramine: 25 mg IV | <input type="checkbox"/> Ondansetron 4 mg IV |
| <input type="checkbox"/> Other: _____ | |

Lab Orders

- CBC w/diff: every _____ weeks month
 CMP: every _____ weeks month
 Other: _____ weeks month

Vyepti (eptinezumab-ijmr)

Dose and Frequency (SELECT ONE)

- IV: infuse 100 mg every 3 months x 1 year
 IV: infuse 300 mg every 3 months x 1 year

*** Following each infusion, flush with 20 mL 0.9% Sodium Chloride. ***

Is the patient on any other disease modifying therapy? Yes No

If yes, please note therapy and last dose: _____

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

PRESCRIBING INFORMATION

Prescriber Name: _____ Signature: _____
 Date: _____ NPI #: _____ Specialty: _____
 Office phone #: _____ Office Fax #: _____