

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ lbs kg

Allergies: _____ NKDA

Patient status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

Migraine G34. _____ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

- Acetaminophen (Tylenol) PO 500 mg 650 mg 1000 mg
- Diphenhydramine (Benadryl) PO IV 25 mg 50 mg
- Methylprednisolone (Solu-Medrol) IV 40 mg 125 mg
- Cetrizine (Zyrtec) 10 mg PO
- Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
<input checked="" type="checkbox"/> VYEPTI (EPTINEZUMAB-JJMR), IV	<input type="checkbox"/> 100 mg	<input type="checkbox"/> Every 3 months
	<input type="checkbox"/> 300 mg	

Refills Zero 12 months _____ Order valid for 1 year unless otherwise stated. _____

- Infuse over 30 minutes.
- Flush with 0.9% sodium chloride at infusion completion.
- Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

- | | | |
|--------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> CBC | <input type="checkbox"/> at each dose | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> CMP | <input type="checkbox"/> at each dose | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> CRP | <input type="checkbox"/> at each dose | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> at each dose | <input type="checkbox"/> every _____ |

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

- Patient Demographics Insurance card Progress Notes supporting DX

Provider Signature _____

Date _____