

**Patient Information**

Name: _____ DOB: _____

Height: _____ ☐ in ☐ cm Weight: _____ ☐ kg ☐ lbs

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate: _____

SSN: _____

**PLEASE INCLUDE ON FAX A COPY OF FRONT
AND BACK OF INSURANCE CARD(S)**

Prescriber

Prescriber name: _____

NPI: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact: _____

Phone: _____ Fax: _____

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ G43 (Migraine)

☐ Other: _____

Allergies: _____

Intravenous Vyepti®**Flushing/Premedication Orders:**

- ✓ Flushing per CoxHealth at Home protocol
 - ✓ PIV: 0.9% sodium chloride 3-20mL before and after infusion as needed
 - ✓ Port: 0.9% sodium chloride 3-20mL into port at time of access or at least monthly, 0.9% sodium chloride 3-20mL before and after infusion as needed, Heparin 100 units/mL 5mL as lock after infusion
 - ✓ Following infusion, flush line with 20mL of 0.9% sodium chloride
- ✓ No routine premedication necessary. If desired, please write here: _____

Vyepti® (eptinezumab) IV over at least 30 min

Frequency:

- ✓ Every 3 months

Dose: ☐ 100mg ☐ Other _____

Quantity to dispense: ☐ 1 dose with 3 refills (1 year) or ☐ _____ infusion(s)

Labs: No routines necessary. If desired, please write here: _____

Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.