

Infusion Order Form

Patient Information:

Patient Name

DOB

Phone Number

Medical Information:

Primary Diagnosis:

☐ Migraine Headaches

ICD-10 Code: G43._____

☐ Other _____

ICD-10 Code: _____

Allergies: _____ (or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
 - Include previously tried and failed therapies
- Relevant labs and tests

Height: _____

Weight: _____

Vyepti (eptinezumab-jjmr) Orders:

- ☐ Administer Vyepti 100 mg IV every 3 months for 12 months (4 doses)
- ☐ Administer Vyepti 300 mg IV every 3 months for 12 months (4 doses)

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

Prescriber's Signature

Date

Prescriber's Printed Name

Contact Phone #:

For Information About Revitalize and or Infusion Plus, please scan the QR code below:



Revitalize



Revitalize Locations



InfusionPlus

October 2025