

# Infusion Order Form

**Patient Information:**

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
**Phone Number**

**Medical Information:**

Primary Diagnosis:

Migraine Headaches

Other \_\_\_\_\_

ICD-10 Code: G43. \_\_\_\_\_

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 its 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 #:**

Please fax the completed order form and all other requested information to: 601-714-1569

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



Revitalize



Revitalize Locations



InfusionPlus