



Please Fax Completed Form To: 88-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION			
Name: DOB:		Prescriber Name:			
Address:		State License:			
City, State, Zip:		NPI #:Tax ID:			
Phone: Alt. Pho	ne:		Address:		
		City, State, Zip:			
Gender: M F Weight:(lbs) Ht:			Fax:		
Allergies:		Office Contact:	Phone:		
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)					
Primary Insurance:		Secondary Insurance (If Applicable):			
Plan #:		Plan #:			
Group #:		Group #:			
RX Card (PBM):		RX Card (PBM):			
BIN: PCN:		BIN:	PCN:		
CLINICAL INFORMATION					
☐ G43.711 Chronic migraine without aura	, intractable, with status migrainosi	us G43.111 Migraine w	ith aura, intractable, with status migrainosus		
☐ G43.711 Chronic migraine without aura, intractable, with status migrainosus ☐ G43.111 Migraine with aura, intractable, with status migrainosus ☐ G43.119 Migraine with aura, intractable, without status migrainosus ☐ Other ICD-10 Code:					
	Date of Diagnosis: Average number of migraine days over the last 3 months:				
Previous Migraine Medications:		,			
VYEPTI® ORDERS					
Prescription type: ☐ New start ☐ Restar	t Continued therapy Total D	oses Received:	Date of Last Injection/Infusion:		
Medication	Dose		Refills		
☐ Vyepti (eptinezumab-jjmr)	☐ 100 mg dose (1-100mg vial)		1 vial (100mg) Refills:		
	☐ 300 mg dose (3-100mg vial)		☐ 3 vials (300mg) Refills:		
☐ Administer the diluted Vyepti solution by IV with a 0.2 or 0.22 μm in-line or add-on sterile filter. Infuse over approximately 30 minutes. Flush the line with 20 mL or 0.9% Sodium Chloride Injection, USP. Repeat dose every 3 months.					
☐ Other:					
Pre-Medication	Dose/Strength		Directions		
☐ Acetaminophen	☐ 500mg	\square Take 1-2 tablets PO prior to infusion or post-infusion as directed			
	☐ 25mg IV/PO	☐ Take 1 tablet PO pric	\square Take 1 tablet PO prior to infusion or as directed OR		
☐ Diphenhydramine	☐ 50mg IV/PO	$\hfill \square$ Inject contents of 1 vial IV prior to infusion or as directed			
	☐ 40mg ☐ 100mg	☐ Inject contents of 1 vial IV prior to infusion or as directed			
☐ Methylprednisolone	☐ 125mg	☐ Other: Inject 100mg IV 30 minutes prior to infusion			
	-				
INFUSION REACTION ORDERS					
Mild reaction protocol:					
☐ Diphenhydramine 25mg IV, one time, for pruritus.					
If symptoms worsen, see orders for moderate to severe reactions.					
I II SYIIIDLOIIIS WOISEII, SEE OIGEIS IOI IIIDGEIG	ate to severe reactions.				

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oximes Acetaminophen 650mg PO, one time, for pyrex	ia or rigors		
$\ oxdot$ Diphenhydramine 50mg IV, one time, for prurit	us or urticaria		
oximes Methylprednisolone 125mg IV, one time, for re	spiratory or neurologic sy	mptoms	
If symptoms worsen, see interventions for severe r	eactions		
Severe reaction protocol: (Call 911 if initiated):			
$\ oxdot$ Titrate oxygen via continuous flow per nasal ca	nnula or face mask to mai	ntain spO2 of greater tha	n ninety-five percent (>95%)
oximes Diphenhydramine 50mg IV,one time, for respir	atory symptoms, edema, o	or anaphylaxis	
oximes Methylprednisolone 125mg IV, one time, for re	spiratory symptoms, eder	na, or anaphylaxis	
oximes Sodium Chloride 0.9% 500mL IV over 30-60 min	n, one time, for cardiovasc	ular symptoms	
☑ Epinephrine 0.3mg/0.3mL IM into mis-anterola	teral aspect of thigh of an	aphylaxis, may repeat x1	in 5-15 minutes if symptoms are not resolved or
worsen			
FLUSHING & LOCKING ORDERS			
Flushing Protocol (>66lbs/33kg)			
PIV and Midline: ☑ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion		Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter: ☑ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw	
Locking Protocol (>66lbs/33kg)			
PIV and Midline: ☑ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	PICC: ⊠ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush		Implanted Port, Tunneled Catheter, and Nontunneled Catheter: ☑ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush
** May substitute Dextrose 5% in Water, or alternative	, for 0.9& Sodium Chloride, v	when indicated due to incor	mpatibility with medications bring infused
SIGNATURE			
We hereby authorize Talis Healthcare LLC to promedicine as prescribed in this referral.	vide all supplies and addition	onal services (nursing/pa	tient training) required to provide and deliver the

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Signature

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Prescriber