



Fax Referrals To: (855) 891-2191  
 Email Referrals To: [referrals@vivoinfusion.com](mailto:referrals@vivoinfusion.com) Have  
 a Question? (855) 478-1528

VYEPTI™ (eptinezumab-jjmr) ORDER FORM  
 (\* - Required Fields)

**STAT REQUEST**  
 (\*REASON MUST BE PROVIDED BELOW)

<b>New Referral</b>	<b>Referral Renewal</b>	<b>Medication/Treatment Change</b>
<b>Benefits Verification Only</b>		<b>Discontinuation Order</b>
<b>PATIENT INFORMATION</b>		
NAME*:	DOB*:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS:	PHONE:	
WEIGHT:      LBS   KG	HEIGHT:	EMAIL:
ALLERGIES:		
<b>PHYSICIAN INFORMATION</b>		
PHYSICIAN NAME*:	PRACTICE NAME:	
ADDRESS:	OFFICE CONTACT*:	
PHONE:	FAX:	EMAIL (FOR UPDATES):
<p>VYEPTI Infusion*:          (SELECT ONE OF THE FOLLOWING)</p> <p style="margin-left: 40px;">100 mg every 3 months</p> <p style="margin-left: 40px;">300 mg every 3 months</p>		
<p>ICD-10*: _____</p>		
Physician Signature* _____		Date*(Referral Valid for One Year) _____
*NPI # _____		<i>Infusion will be administered per MPP policy and protocols</i>
<b>ICD-10 Description:</b>	<b>REQUIRED DOCUMENTATION CHECKLIST:</b>	
<p><b>*STAT REASON:</b>          (STAT requests will be assessed per MPP policy and protocols)</p> <p>Last Infusion/Injection Date: _____</p>	<p>Patient Demographics</p> <p>Insurance Card/Information</p> <p>Progress Notes supporting DX</p> <p>Current Medication List and H&amp;P</p>	
STANDING LAB REQUEST (to be drawn by clinic):	CMP	CBC *Frequency _____
Additional comments/notes:		

**Locations:**

-----Colorado-----

Lakewood

-----Florida-----

Jacksonville  
 Kissimmee  
 Port St. Lucie  
 Suncoast  
 Winter Park

-----Ohio-----

Beachwood  
 Middleburg Hts.  
 Painesville  
 Youngstown  
 Westlake  
 Fairlawn

-----Oklahoma-----

Tulsa

-----Texas-----

Arlington  
 Cedar Hill  
 Dallas  
 Denton  
 Ft. Worth  
 Irving  
 Rockwall  
 Southlake  
 Flower Mound  
 Plano  
 Tyler