

**NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.**

PATIENT INFORMATION			
Name:			DOB:
Allergies:		Date of Referral:	
REFERRAL STATUS			
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency Change	
<input type="checkbox"/> Order Renewal			
INFUSION OFFICE PREFERENCES (Optional)			
Preferred Location* <input type="checkbox"/> Mattoon		<input type="checkbox"/> Effingham	
*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Migraine without aura			ICD 10 Code: G43.009
<input type="checkbox"/> Chronic Migraine without Aura			ICD 10 Code: G43.709
<input type="checkbox"/> Chronic Migraine without Aura, Intractable, with status migrainosus			ICD 10 Code: G43.711
<input type="checkbox"/> Chronic Migraine without Aura, Intractable, without status migrainosus			ICD 10 Code: G43.719
<input type="checkbox"/> Other: _____			ICD 10 Code: _____
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)			
<input type="checkbox"/> This signed order form by the provider		<input type="checkbox"/> Clinical/Progress notes (must be within 1 year)	
<input type="checkbox"/> Patient demographics AND insurance information		<input type="checkbox"/> Labs and Tests supporting primary diagnosis	
*Patient may be required to submit a pregnancy test prior to treatment			
List Tried & Failed Therapies, including duration of treatment:			
1)			
2)			
3)			
MEDICATION ORDERS			
Dosing Wt for Calculations	Ht:	Wt:	BMI:
Initial Dosing	<input type="checkbox"/> J3032 Vyepti 100mg IV every 3 months		
	<input type="checkbox"/> J3032 Vyepti 300mg IV every 3 months		
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.			
Duration	<input type="checkbox"/> X 6 months	<input type="checkbox"/> X 1 year	<input type="checkbox"/> _____ doses
ADDITIONAL ORDERS / INFORMATION			
PRESCRIBER INFORMATION			
Prescriber name :			
Office Phone:	Office Fax:	Office Email:	
Prescriber Signature:	Date:	Time:	

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:

Fax Completed Form and all documentation to:

MATTOON  
1000 Health Center Dr. Ph. 217-258-4150  
Suite 204 Fax 217-348-2579  
Mattoon, IL 61938

EFFINGHAM  
901 Medical Park Dr. Ph. 217-342-7500  
Suite 201 Fax 217-342-7499  
Effingham, IL 62401