

Vyepti Request Form

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Is this a Continuation of Care or a new start to the medication?

- ☐ Continuation of Care (Provide documentation of last administration)
☐ New Rx

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI Tax ID#	Name: NPI: Tax ID#
Fax Number	
Practice Contact (Name/Phone number)	
Email of Contact	
<p><i>We will gladly remind your patient to schedule routine follow-up visits with your office.</i></p> <p>Return to Referring Provider (frequency): EVERY _____ WKS / MOS</p>	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: Weight in lbs:	
Insurance(s): include copies of front and back	

Preferred Treatment Location	<input type="checkbox"/> Voorhees <input type="checkbox"/> Wall/Manasquan <input type="checkbox"/> Hamilton <input type="checkbox"/> Moorestown <input type="checkbox"/> Sewell <input type="checkbox"/> Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

Diagnosis:

□ G43. _____

The following information is required for Vyepti prior authorization:

- For chronic migraines, how many migraine/tension-like headaches does the patient have per month? _____
- For episodic migraines:
 - How many migraines per month? _____
 - How long do the headaches usually last? _____
 - Do the migraines significantly diminish the patient's quality of life? □ YES
 - Has the patient tried/failed 2+ migraine meds? □ YES □ NO
 - Which ones? _____
 - Without Vyepti, is the patient at risk of medication overuse headache? □ YES □ NO
 - How many headache days/month does the patient have? _____
 - Has headache medication overuse been ruled out? □ YES □ NO
 - Has the patient failed 1+ migraine prophylaxis? □ YES □ NO
 - Which one(s)? _____
 - If the patient is using Botox for prophylaxis, will they stop using it once starting Vyepti? □ YES □ NO
 - If not, why? _____
 - If the patient is using a cGRP antagonist, will they stop using it once starting Vyepti? □ YES □ NO
 - If not, any reason why? _____

PLEASE NOTE:

- Please include a copy of RX to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required.

- **** NOTE **** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- **!! IMPORTANT !!** *Please notify our office if the medication is discontinued.*

Ordering Provider Signature: _____