866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
www.REPharmacy.com

RE Pharmacy Referral Form

Vyepti (eptinezumab-jjmr) IV Infusion for Migraine

Send your RX to:

____

Date Medication Needed: ____________________________________

Ship to: ☐ Patient's Home ☐ Prescriber's Office ☐ Pick-up (store location): _________________________

1. PATIENT & INSURANCE INFORMATION

(Please include copies of the FRONT and BACK of ALL insurance cards with this fax - Prescription and Medical)

Patient Name: ____________________________ Birth Date: _______________ Gender: ☐ Male ☐ Female

Height: _______________ Weight: _______________ ☐ lbs. ☐ kg.

SS#: ____________________ Preferred Phone: ________________ Known Allergies: ____________________

____

Address: _______________________City: _______________________ State: __________ ZIP: _____________

Insurance Info: ________________________________ Policy Number: _________________________________

2. PRESCRIBER INFORMATION

Provider Name: ____________________________ DEA#: _________ NPI#: __________TAX ID#: __________

Address: _______________________________ Phone: _____________________ Fax: ____________________

City, State, ZIP: _________________________ Key Contact: ________________ Phone #: _______________

4. DIAGNOSIS / CLINICAL INFORMATION

(To expedite prior authorization, please FAX any/all recent clinical notes, medication lists, and lab results/tests along with the prescription)

☐ Acute Migraine ☐ Chronic Migraine

Indication:

☐ Preventive treatment of Migraine in Adult ☐ Other: ____

History of headaches:

Date headaches began: ______________ Duration of daily headaches: _________☐ Hours ☐ Minutes

Frequency - Number of daily headaches per month : _____________ ***OR*** number of headache-free days per month: __________

Symptoms: ☐ Moderate/severe pain ☐ Nausea ☐ Vomiting ☐ Photophobia ☐ Phonophobia ☐ Unilateral ☐ Pulsating

Other considerations (please describe): ____

Previous Prophylactic or Treatment Drug Class Prescribed within the past three months:

Drug name: _____________________________________ Dose: ______________ Duration: ______________

Outcome(s): ☐ Not effective ☐ Contraindicated ☐ Intolerant ☐ Failed ☐ Suboptimal

☐ OTHER: ____

RE PHARMACY
PASSION FOR LIFE

3. PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSAGE	# OF VIALS	# OF REFILLS
Vyepti (eptinezum-ab-jjmr) IV Infusion for Migraine.	100mg/ml SDV	☐ 100mg IV over 30mins every 3 months ☐ 300mg IV over 30 mins every 3 months		
		SUPPLIES ☐ YES ☐ NO ☐ 100 ml 0.9% Normal Saline Bag ☐ Other: ______		
		LOCATION OF ADMINISTRATION ☐ Dr. Office ☐ Home ☐ Infusion Center		

4. PATIENT SUPPORT PROGRAMS

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

______________________ ______________________

Patient Signature Date

5. PRESCRIBER SIGNATURE

Prescriber, please sign and date below. Please attach all patient-related document here.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

______________ ______________ ______________ ______________

Dispense as written Date Substitution Permissable Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

#of Prescriptions

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