Horizon Infusions

vyepti™ (eptinezumab-jjmr)

Select location:

- ☐ Akron
- ☐ Anderson
- ☐ Athens
- ☐ Canton
- ☐ Cincinnati (Blue Ash)
- ☐ Cincinnati (West Side)
- ☐ Cleveland (Mayfield)
- ☐ Cleveland (North Olmsted)
- ☐ Columbus (East Broad)
- ☐ Columbus (Hilliard)
- ☐ Columbus (Worthington)
- ☐ Dayton (Beavercreek)
- ☐ Dayton (Englewood)
- ☐ Findlay
- ☐ Liberty
- ☐ Mansfield
- ☐ Perrysburg
- ☐ Springfield
- ☐ Toledo
- ☐ Warren
- ☐ Crestview Hills (NKY)

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	**DOB:**
Phone:	**Other Phone:**
Email:	
Social Security #:	**Allergies:**
Gender: ☐ M ☐ F	**Weight:** ☐ Lbs ☐ Kg

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date ***(if applicable)***:

2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		**NPI#:**
License #:	**TIN#:**	**DEA#:**
Address:		
City:		**State** **Zip**
Office Contact:		**Email:**
Office phone:		**Office fax:**

4 . DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

☐ **Migraine (_____)** ☐ **Other: _____**

5. PRESCRIPTION INFORMATION (*requires new order every 12 months*) *Phosphorus level required prior to initial infusion

VYEPTI

☐ **Administer** ☐ **100mg IV** ☐ **300mg IV Q3 months**

☐ **Vital signs per HI Protocol**

☐ **Anaphylaxis & Hydration Management per HI Protocol**

PRE-MEDICATIONS ☐ **N/A**

- ☐ **Acetaminophen** ☐ **500mg** ☐ **650mg** ☐ **1000mg**
- ☐ **Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)**
- ☐ **Diphenhydrimine (Benadryl)** ☐ **25mg** ☐ **50mg** ☐ **PO** ☐ **IV (requires driver)**
- ☐ **Methylprednisolone (Solu-Medrol)** ☐ **40mg** ☐ **80mg** ☐ **125mg IV**
- ☐ **Prednisone _____ mg PO**
- ☐ **Other _____**

POST-MEDICATIONS ☐ **N/A**

- ☐ **Acetaminophen** ☐ **500mg** ☐ **650mg** ☐ **1000mg**
- ☐ **Prednisone _____ mg PO**
- ☐ **Other _____**

6. LABS

☐ **CBC w/Diff**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **CRP**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **CMP**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **ESR**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **Hepatic Panel**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **Renal Panel**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**

☐ **Quantiferon TB Gold, annually, last completed *(date)*: _____**

☐ **Other (*specify*):_____**

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE **DATE**