

Vyepti Enrollment Form

TwelveStone Health Partners



Date: _____
 Patient Name: _____
 Date of Birth: _____

Fax Referral To:
(800) 223-4063
 Direct Phone: (615) 278-3350
 Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Infusion Date: _____ Next Infusion Date: _____	<input type="checkbox"/> Physician's Office TwelveStone Infusion Center: <input type="checkbox"/> Canton <input type="checkbox"/> Chattanooga <input type="checkbox"/> Knoxville <input type="checkbox"/> Mount Juliet <input type="checkbox"/> Murfreesboro <input type="checkbox"/> Other: _____ Desired Start Date: _____

DIAGNOSIS

Description <input type="checkbox"/> Migraine <input type="checkbox"/> Other: _____	ICD-10 Code <input type="checkbox"/> G43.0 <input type="checkbox"/> Other: _____
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OTHER REQUIRED DOCUMENTATION (Please attach required documents)

<input type="checkbox"/> This signed order form	<input type="checkbox"/> History and Physical
<input type="checkbox"/> Patient Demographics and Insurance Information	<input type="checkbox"/> Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

Patient Weight: _____ Kg Height: _____ Inches/CM BSA : _____ Allergies: _____
 Line Access: PIV PICC (SL DL TL) PORT (Huber size _____ Gauge _____ Length) Other Access: _____

MEDICATION	DIRECTIONS	REFILLS	
<input type="checkbox"/> Vyepti	<input type="checkbox"/> Infuse _____ mg IV over 30 minutes every 3 months.		

LAB ORDERS (to be drawn by TwelveStone)

Order	Frequency
CBC w/Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CBC w/o Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
BMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CRP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Sed Rate	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Calcium	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Tb QuantiFERON Gold	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Hepatitis Panel	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Other _____	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____

PRE-MEDICATIONS/No Pre-Meds please check here _____

Oral	IV
Acetaminophen: <input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg	Dexamethasone: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Cetirizine: <input type="checkbox"/> 10mg	Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg
Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	Methylprednisolone: <input type="checkbox"/> _____mg IV over _____ mins
Ibuprofen: <input type="checkbox"/> 200mg	Ondansetron: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Loratidine: <input type="checkbox"/> 10mg	
Ondansetron: <input type="checkbox"/> 4mg	

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone # _____	Physician's NPI# _____	Physician's Fax # _____	Physician's Address _____
Dispense as Written _____	Date _____	Substitution Allowed _____	Date _____

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