

**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**

<b>If YES, please provide the following information:</b>	<b>If NO, please indicate desired location for first dose:</b>
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**

<b>Description</b> <input type="checkbox"/> Migraine <input type="checkbox"/> Other: _____	<b>ICD-10 Code</b> <input type="checkbox"/> G43. _____ <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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