Vyepti Order Form

Select patient referral location: Akron Athens Blue Ash Cleveland Columbus Crestview Hills Dayton Mansfield Perrysburg Springfield Toledo West Cincinnati

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 *(andyearofdiagnosis)*

Migraine (_______) ICD 10 (______) 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