VEROS HEALTH®
Excellence in Complex Care

Migraine Referral Form

Please complete the following and fax with clinical documentation to: 720.870.2414

Referral Process

1. PATIENT INFORMATION			2. PHYSICIAN INFORMATION		
Name:			Physician's name:		
Address:			License #:	NPI #:	
City:	State:	Zip:	DEA #:		
Home Phone:	Other Phone:		Address:		
Email:			City:	State:	Zip:
DOB:	Social Security #:		Office Contact:		
Gender: ☐ M ☐ F	Height:	Weight:	Phone:	Fax:	
Allergies:					

3. DIAGNOSIS

Year of diagnosis: _____

☐ (G43.____) Migraine ________________________________ ☐ Other: ________________________________

Number of migraine days/month: _____

List drugs that have been previously tried but failed: _____

4. INSURANCE INFORMATION

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

5. PRESCRIPTION INFORMATION

Anticipated Start Date: _____

Aimovig® (erenumab-aooe) 70 mg/ML SureClick®:

☐ Inject 70 mg **OR** ☐ inject 140 mg Frequency: Subcutaneous once monthly

Dispense: ☐ One 70 mg/ML SureClick® ☐ Two 70 mg/ML SureClick® ☐ Dispense as written Refills: _____

Ajovy® (fremanezumab-vfrm) 225 mg/1.5 mL solution in a single-dose prefilled autoinjector or 225 mg/1.5 mL solution in a single-dose prefilled syringe

☐ 225 mg subcutaneous injection monthly

☐ 675 mg subcutaneous injection every 3 months, administered as 3 consecutive injections of 225 mg each

Refills: _____

Vyepti® (eptinezumab-jjmr)* 100 mg/mL solution in a single-dose vial for intravenous use:

☐ 100mg IV over 30 minutes every 3 months ☐ 300mg IV over 30 minutes every 3 months Refills: _____

Dilute each dose in 100 mls 0.9% Sodium Chloride prior to infusing IV over 30 minutes

***Skilled Nursing Services are required**

Access: ☐ N/A ☐ Peripheral Other: _____

FLUSH ORDERS ☐ N/A

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated

☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml

Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml.

ANAPHYLAXIS ORDERS

☐ **Adults**: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.

For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

☐ Other: ________________________

Additional orders: ____

Additional Instructions: ____

6. PHYSICIAN'S SIGNATURE (required): ________________________________ Date: _____

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Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.