

**ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER**

**ALLERGIES/REACTIONS (REQUIRED):**

Yakima Outpatient Infusion Care  
808 N 39<sup>th</sup> Ave Yakima WA 98902  
Phone: 509-575-1174  
Fax: 509-577-5021

**ORDERS WITH CHECK BOXES**

When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

**CODE STATUS**

Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

**EPTINEZUMAB-JJMR (Vyepiti)**

Patient Name: \_\_\_\_\_ Requested Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Weight: \_\_\_\_\_ kg Patient Height: \_\_\_\_\_

**DIAGNOSIS & ICD-10 CODE:**

Migraine, prophylaxis (ICD-10: \_\_\_\_\_)       Other: \_\_\_\_\_ (ICD-10: \_\_\_\_\_)

**REQUIRED:** H&P with documentation to support above diagnosis including ICD-10 code and supporting labs

**\*\*If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available\*\***

**ACCESS:** Access and maintain IV site or Port-A-Cath in accordance with the appropriate MYM OIC P&Ps

**TREATMENT REGIMEN:** (another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)

**Eptinezumab-jjmr (Vyepiti)**

- 100 mg (diluted) IV over 30 minutes every 12 weeks
- 300 mg (diluted) IV over 30 minutes every 12 weeks
- Other: \_\_\_\_\_

**MONITORING:** Vitals at baseline and at completion of infusion.

**PATIENT EDUCATION:** Signs and symptoms of hyperglycemia and medication-associated hyperglycemia management

**SUPPORTIVE CARE:** Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

**DISCHARGE:** 30 minutes after infusion is complete when vital signs are stable and hypersensitivity symptoms are absent. Waiting period can be waived by patient on subsequent infusions.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print name: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

**\*\*Expires 12 months from written date\*\***

**Patient Identification - Attach Patient Label**

Name:  
MRN:  
Age / Sex and Gender:

**EPTINEZUMAB-JJMR (Vyepiti)**  
**MultiCare**   
**Yakima Memorial Hospital**