SA Infusion Services

VYEPTI

Email all Referrals to: *info@sainfusion.com.au*
OR Fax to: (08) 7081 7038

139, Payneham Rd,
St Peters SA 5069

PATIENT DETAILS

Name: _____

Address: _____

Date of Birth: _____

Contact Phone: _____

REFERRER DETAILS (or stamp)

Doctor Name: _____

Provider No.: _____

Practice: _____

Fax or Email: _____

PATIENT SCREENING

Patient Age: _____

Is the patient pregnant?

○ Yes ○ No

Is the patient breastfeeding?

○ Yes ○ No

Allergies:

_____

CLINICAL INDICATION

☐ Chronic Migraine

☐ Episodic Migraine

☐ Other - *please specify:*

_____

TREATMENT ORDER

☐ Vyepti 100 mg IV infusion every 12 weeks

☐ Vyepti 300 mg IV infusion every 12 weeks

First Dose ☐ Continuing Treatment ☐

REFERRER CHECKLIST

(please tick each to confirm)

- ☐ I have provided the patient with a valid prescription for IV Vyepti
- ☐ I confirm that the patient is clinically stable & suitable for outpatient IV Vyepti infusion
- ☐ I confirm I have discussed all the risks, benefits and potential side effects of IV Vyepti with the patient and have obtained fully informed consent from the patient for treatment with IV Vyepti

REFERRER ACKNOWLEDGEMENT

By signing this referral form, the referrer confirms that they have assessed that it is clinically appropriate for the referred patient to receive IV Vyepti (Eptinezumab), specifically in an outpatient setting, and confirms that all relevant contraindications, precautions, patient comorbidities, medication history, and allergy history have been reviewed by the referrer in making this clinical decision, prior to referral.

By signing this referral form, the referrer also fully acknowledges and accepts that SA Infusion Services provides an administration service only, and that responsibility for diagnosis, determination of treatment suitability & clinical eligibility, prescribing, treatment sequencing, ongoing monitoring, follow-up care, and overall clinical management of the referred patient remain solely the responsibility of the referrer.

Date: _____ Referrer Signature: _____