



139, Payneham Rd,
St Peters SA 5069

VYEPTI

Email all Referrals to: info@sainfusion.com.au

OR Fax to: (08) 7081 7038

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:
