

Eptinezumab-jjmr (Vyepti & Biosimilars) Infusion Order Form**Patient Name:** _____**Date of Birth:** _____**Patient Phone #:** _____**Date:** _____**Therapy Status:** ☐ New Start ☐ Continuation ☐ Restart**Last Dose:** _____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____

J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)☐ Labs to be reviewed or ordered by infusion center☒ Baseline☐☒ Maintenance (every _____)☐☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)☐ Other: _____**Provider Information**

Hypertension: New-onset or worsening of preexisting hypertension may occur.

Raynaud's Phenomenon: New-onset or worsening of pre-existing Raynaud's phenomenon may occur.

Nursing Order☒ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.**Pre-Medications (Not routinely recommended, use only if clinically indicated)**☐ Acetaminophen 650 mg PO once☐ Dexamethasone 20 mg IV once☐ Diphenhydramine 25 mg PO once☐ Dexamethasone 20 mg PO once☐ Diphenhydramine 25 mg IV once☐ Methylprednisolone 125 mg IV once☐ Diphenhydramine 50 mg PO once☐ Methylprednisolone 40 mg IV once☐ Diphenhydramine 50 mg IV once☐ Other: _____☐ Famotidine 20 mg IV once☐ Famotidine 20 mg PO once**IV Site Orders**

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- ☒ Follow standard protocol for IV site management
- ☒ In absence of standard protocol, follow the orders below:
 - ☒ Sodium chloride 0.9% infusion 250 mL IV at 20 mL/hr PRN (carrier fluid/KVO)
 - ☒ Start peripheral IV or access central line for infusion
 - ☒ Sodium chloride 0.9% 10 mL flush to IV site as needed
 - ☒ Heparin 50 units/5 mL flush to IV site as needed (central line only)
 - ☒ Heparin 500 units/5 mL flush to IV site as needed (central line only)
 - ☒ May use alteplase 2 mg intracatheter as needed for negative blood return of IV site

Medication Orders (select only one)

- ☐ Eptinezumab 100 mg IV once over 30 minutes every 3 months
- ☐ Eptinezumab 300 mg IV once over 30 minutes every 3 months

Refills:

(Refills for one year from date of signature unless indicated)

- ☐ Zero
 ☐ For 12 months
 ☐ _____

To be completed by Infusion Center staff only:

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
 Rounded Dose: _____ mg

Rationale for Substitution:

- ☐ Payer-mandated substitution
- ☐ Financial stewardship
- ☐ Patient access / hardship

Pharmacy may adjust dose $\pm 10\%$ of ordered dose per approved protocol. Pharmacy may substitute a biosimilar based on insurance coverage.

Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

Infuse through a 0.2 micron inline filter.

Emergency / Hypersensitivity Orders

- ☒ Notify provider for next steps once patient stabilized
- ☒ Follow standard orders for management of allergies and anaphylaxis reactions
- ☒ In absence of standard protocol, follow the orders below:
 - ☒ Nursing to stop infusion, maintain airway, place supine, elevate legs, O₂ 2 L NC
 - ☒ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
 - ☒ Diphenhydramine 25 mg IV q6h PRN itching/hives
 - ☒ Hydrocortisone 100 mg IV Once PRN hypersensitivity
 - ☒ Methylprednisolone 125 mg IV Once PRN hypersensitivity
 - ☒ Famotidine 20 mg IV Once PRN hives/itching



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- ☒ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
- ☒ Normal Saline 1000 mL IV bolus Once PRN hypotension

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated