



**MICHIGAN INSTITUTE FOR NEUROLOGICAL DISORDERS (MIND) INFUSION
TREATMENT REFERRAL FORM**

Infusion Center Locations: CHECK ONE: **MIND Farmington Hills** **MIND Roseville**
28595 Orchard Lake Rd 25100 Kelly Road
Farmington Hills, MI 48334 Roseville, MI 48066

Main telephone Number: 248.553.0010 Fax Number: 248.553.6222 www.mindonline.com

Patient Name: _____ Date of birth: _____

Patient Address: _____ Phone Number: _____

Allergies: _____

VYEPTI (EPTINEZUMAB-JJMR)

Please include diagnosis/ICD Code: _____

Date of Last migraine treatment: Type: _____ Dose: _____ Date: _____

Please Include:

- Copy of Insurance Card(s) (front and back)
- Copy of Driver's License (front and back)
- Clinical progress notes/labs/tests supporting primary diagnosis
- Current History and Physical with updated medication list included
- Most recent MRI

Infusion Orders: **Vyepti:** 100 mg every 13 weeks OR 300mg every 13 weeks

Dose Number: _____ (if patient has had previous infusions)

PRN Medications: Benadryl 25mg IVP Zofran 4mg IVP Other: _____

Additional Orders: _____

By signing this form and utilizing our services, you are authorizing MIND and its employees to serve as your prior authorization and pharmacy designated agent in dealing with medical and prescribing companies.

Physician Name: _____

Physician Signature: _____ Date: _____

Phone number: _____ Fax Number: _____

Additional Services available at MIND

Mark needed services and a MIND representative will reach out for further information

- MRI** **EEG** **EMG** **OCT**