RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Vypeti Referral Order Form

Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Contact Fax #:	Office Contact Email:

Vypeti Medication Orders

Dosage

- ______ 100mg IV every 3 months
- ______ 300mg IV every 3 months
- ______ Other ____

Patient Weight: ________ Lbs or _______ Kg

Diagnosis with ICD 10 code **(REQUIRED)**

- Diagnosis: ______ Migraine prophylaxis
- ICD 10 code ____

Pre-Medication	Refills
• Tylenol ________mg • Benadryl _______ mg __IV or ___PO	• Zero ________ • Treatments for 1 year ___________
• Solumedrol IV Push _______ mg • Other _________________	• Other ________

Required Documentation

○ **Insurance Cards (Front and Back)**	○ **Patient Demographics**	○ **Recent Progress Notes**
Special Instructions/Notes		

_________________________________ **Prescribing Provider Signature**

_____________________ **Date of Signature**