

Vyepti® (Eptinezumab-jjmr) Prior Authorization Form

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

Pharmacy billing (NDC: _____ **) Physician billing (HCPCS code:** _____ **) Dose:** _____
Regimen: _____ **Fill Quantity/Day Supply:** _____ **Start date (or date of next dose):** _____

Billing Provider Information

Provider NPI: _____ **Provider Name:** _____
Provider Phone: _____ **Provider Fax:** _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____
Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Criteria

All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization (Initial approval will be for the duration of 3 months):

1. What is the member's diagnosis?
 - Preventative treatment of migraines in adults
 - Other, please list: _____
2. Does the member have documented:
 - Chronic Migraine Headache
 - Episodic Migraine Headache
3. Date of member's migraine diagnosis? _____
4. Number of headache days per month? _____
5. Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? _____
6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated?
 - a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes ___ No ___
 - b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes ___ No ___
7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated?
 - a. Hormone replacement therapy or hormone-based contraceptives? Yes ___ No ___
 - b. Chronic insomnia? Yes ___ No ___
 - c. Obstructive sleep apnea? Yes ___ No ___
8. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes ___ No ___ If yes, please list:

Medication _____	Date Span _____	Dosing _____
Medication _____	Date Span _____	Dosing _____
Medication _____	Date Span _____	Dosing _____
9. If the trial duration for the medication(s) listed above is not a least 8 weeks, please document the reason(s):
Medication(s) _____
Reason(s) for discontinuation prior to 8 weeks: _____
10. Is the member taking any of the following medications **known** to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain?
 - a. Decongestants (alone or in combination products)? Yes ___ No ___
 - b. Combination analgesics containing caffeine and/or butalbital? Yes ___ No ___
 - c. Opioid-containing medications? Yes ___ No ___
 - d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes ___ No ___
 - e. Ergotamine-containing medications? Yes ___ No ___
 - f. Triptans? Yes ___ No ___

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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Vyepti® (Eptinezumab-jjmr) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Criteria

All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization (continued):

11. Is the member taking any of the medications, listed in Question 10., **known** to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain?
 - a. If yes, to any of the medication(s) listed in Question 10., please list the medication(s) and the number of days per month taken: _____
 - b. If yes, to any of the medication(s) listed in Question 10., please provide additional information to support member's need for continued use of medication(s) known to cause overuse or rebound headaches: _____
12. Is the member taking any medications that are **likely** to be the cause of the headaches? Yes ___ No ___
13. Has the member been evaluated within the last six months by a neurologist for migraine headaches and was Vyepti® recommended as treatment? Yes ___ No ___
 - a. If yes, please include name of neurologist recommending Vyepti® treatment _____
14. Will member use Vyepti® concurrently with botulinum toxin for the prevention of migraine or with an alternative calcitonin gene-related peptide (CGRP) inhibitor? Yes ___ No ___
15. If applicable, are other aggravating factors that contribute to the development of episodic/chronic migraine headaches being treated (e.g., smoking)? Yes ___ No ___ Not Applicable ___
16. Will Vyepti® be prepared and administered according the Vyepti® *Prescribing Information*? Yes ___ No ___
17. Please provide a patient-specific, clinically significant reason why the member cannot use Emgality® (galcanezumab-gnlm) or Ajovy® (fremanezumab-vfrm): _____
18. If the maximum recommended dosing (300mg every 3 months) for Vyepti® is being requested, please provide a patient-specific, clinically significant reason why other available CGRP inhibitors for migraine prophylaxis are not appropriate for this member: _____

For Continued Authorization (Compliance and information regarding efficacy will be required for continued approval):

1. Has the member been compliant with Vyepti® (eptinezumab-jjmr) treatment? Yes ___ No ___
2. Has the member responded well to treatment with Vyepti® (eptinezumab-jjmr)? Yes ___ No ___
3. Please provide the member's current number of migraine days per month: _____

Additional Information: _____

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Please complete and return all pages. Failure to complete all pages will result in processing delays.

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p style="text-align: center;">University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p style="text-align: center;">Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p style="text-align: center;"><u>CONFIDENTIALITY NOTICE</u></p> <p style="text-align: center;"><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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