

Antimigra ine Agents, Vyepti[®] (Eptinezuma b-jmmr) Prior Authorization (PA) Form

HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

01/15/1990

If the following information information complete, correct, or legible PA process can be delayed: Page one form per member.

Member Information														
Last name:	First name ⁵													
Johnson Medicaid ID number:	Dr. Sarah 1234567890 Date of birth:													
Weight in kilograms:														
Prescriber information Vyepti	Injection.													
Last name:	Injection First name:													
NPI number:														
Phone number:	Fax number:													
Drug information														
Drug name: Drug strength: Length of therapy:	Drug form: Dosing frequency: Quantity:													

(Form continued next page.)

Antimigraine Agents, Vyepti® (Eptinezumab-jmmr) Prior Authorization (PA) Form Page 2 of 3 Member's last name: Member's first name: Drug information (continued) Preventive treatment of migraine Non-preferred agents (PA required) Preferred agents *step edit required Aimovig®, Ajovy® and Ajovy® autoinjector Emgality® syringe (100 mg) Emgality® pen and syringe (120 mg), Nurtec® ODT Qulipta™, Vyepti® Acute treatment of migraine Preferred agents (No SA with trial of 2 generic triptans) Non-preferred agents (PA required) Nurtec® ODT, Ubrelvy™ Reyvow®, Trudhesa™, Zavzpret™ Identify why the preferred agents cannot be used: Χ **Drug** information Χ All drugs in this class are eligible to receive a six-month approval. Complete the following questions. For preventive treatment of migraine, does the member meet the *step edit and the following criteria? Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria? AND ☐ Yes 2. Is the member ≥ 18 years of age? AND ☐ Yes □ No Has the member been utilizing prophylactic intervention modalities (for example, pharmacotherapy, behavioral therapy, physical therapy, etc.)? AND ☐ Yes □ No Does the member have a diagnosis of chronic migraines defined as 15 or more headache (tension-type-like and/or migraine-like) days per month for > three months? AND a. Member has had at least five attacks with features consistent with migraine (with and/or without aura); AND b. On at least eight days per month for > three months: i. Headaches have characteristics and symptoms consistent with migraine; OR ii. Member suspected migraines are relieved by a triptan or ergot derivative medication; c. Member has failed at least an eight-week trial of any two oral medications for the prevention of migraines (for example, antidepressants, beta blockers, antiepileptics) prior to initiation of eptinezumab: AND

d. Member had an inadequate response (or unable to tolerate) a minimum trial of at least two

preferred self-injectable CGRP options; OR

□ No

(Form continued next page.)

☐ Yes

Antimigraine Agents, Vyepti® (Eptinezumab-jmmr) Prior Authorization (PA) Form Page 3 of 3

Member's last name:										Me	Member's first name:											
5.	. Does the member have diagnosis of frequent episodic migraines defined as at least five headache attacks lasting 4 to 72 hours (when untreated or unsuccessfully treated)? AND																					
	 a. Headaches have characteristics and symptoms consistent with migraine without aura; AND b. Medication overuse headache has been ruled out by trial and failure of titrating off acute migraine treatments in the past AND 																					
	□ Yes □ No																					
6.	Will Vyepti not be used in combination with prophylactic calcitonin gene-related peptide (CGRP) inhibitors? (for example, erenumab, galcanezumab, fremanezumab, atogepant, rimegepant, etc.)																					
	□Ye	es		No																		
For	For renewal, complete the following questions to receive a 12-month approval:																					
1.																						
	□ Yes □ No																					
2.	Does the member have an absence of unacceptable toxicity from the drug? AND																					
	□ Yes □ No																					
3.	Has the member experienced a clinical response as evidenced by:																					
	 Reduction in mean monthly headache days (MHD) of at least moderate severity of ≥50% relative to the pretreatment baseline (diary documentation or medical professional attestation); OR 																					
	 A clinically meaningful improvement in ANY of the following validated migraine-specific membe reported outcome measures: 													er-								
	 i. Reduction of ≥5 points when baseline score is 11 to 20 OR reduction of ≥30%when baseline score is >20 in the MIDAS (Migraine Disability Assessment) scores; OR ii. Reduction of ≥5 points in the MPFID (Migraine Physical Function Impact Diary) score; OR iii. Reduction of ≥5 points in the HIT-6 (Headache Impact Test) score 																					
	□ Yes □ No																					
Prescriber signature (required) Date																						
	By signature, the physician confirms the above information is																					
C	accurate and verifiable by member records.																					
Р	Please include all requested information; Incomplete forms will delay the PA process.												the P	A pro	cess.							

Submission of documentation does **not** guarantee coverage.

The completed form may be **faxed to 844-512-7020**.