Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

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

HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

Member Information

Last name: | First name:

Medicaid ID number: | Date of birth: – –

Weight in kilograms: _____

Prescriber information

Last name: | First name:

NPI number:

Phone number: – – | Fax number: – –

Drug information

Drug name: _____ | Drug form: _____

Drug strength: _____ | Dosing frequency: _____

Length of therapy: _____ | Quantity: _____

(Form continued next page.)

VABCBS-CD-061331-24-SRS6111 June 2024 Effective 07/01/2024

Member's last name: **Member's first name:**

Drug information (continued)

Preventive treatment of migraine	
Preferred agents *step edit required	Non-preferred agents (PA required)
Aimovig®, Ajovy® and Ajovy® autoinjector Emgality® pen and syringe (120 mg), Nurtec® ODT	Emgality® syringe (100 mg) 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:

Drug information

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?

1. 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 ☐ No

2. Is the member ≥ 18 years of age? AND

   ☐ Yes ☐ No

3. Has the member been utilizing prophylactic intervention modalities (for example, pharmacotherapy, behavioral therapy, physical therapy, etc.)? AND

   ☐ Yes ☐ No

4. 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; AND
   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

      ☐ Yes ☐ No

(Form continued next page.)

Member's last name: **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.)

    ☐ Yes ☐ No

For renewal, complete the following questions to receive a 12-month approval:

1. Does the member continue to meet the initial criteria? AND

    ☐ 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:
    a. 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
    b. A clinically meaningful improvement in ANY of the following validated migraine-specific member-reported outcome measures:
        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 accurate and verifiable by member records.

Please include all requested information; Incomplete forms will delay the PA process.
Submission of documentation does **not** guarantee coverage.
The completed form may be **faxed to 844-512-7020**.