OKLAHOMA Health Care Authority

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State of Oklahoma
SoonerCare
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

Provider NPI:_____ Provider Name_____

Provider Phone:_____ Provider Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

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

1. What is the member's diagnosis?
   - ☐ Preventive 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. Has the member been evaluated for all of the following, as defined by the American Headache Society, and these conditions have been ruled out and/or treated:
   a. Red flags? Yes☐ No☐
   b. Possible indicators of secondary headache? Yes☐ No☐
   c. Medication overuse? Yes☐ No☐
7. 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☐
8. Please provide a patient-specific, clinically significant reason (beyond convenience) why member cannot use Aimovig®, Ajovy®, and Emgality®: _____
   _____
9. Will Vyepti® be prepared and administered according to the Vyepti® package labeling? Yes☐ No☐
10. If request is for the maximum recommended dosing (300mg every 3 months), please provide a patient-specific, clinically significant reason why other available CGRP inhibitors for migraine prophylaxis are not appropriate for the member: _____
    _____

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *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.*

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Criteria

For Continued Authorization:

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

Additional Information: _____

_____

_____

_____

_____

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.

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