SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Vyepti™ (eptinezumab) **(Pharmacy) (Non-Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage: 100mg intravenously every 3 months; individuals who do not respond to 100mg may be approved for 3 vials (300mg) every 3 months.

****Vyepti is unproven and not medically necessary for:**

- Acute attack of migraine
- Episodic cluster headache

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization Approval: 6 months

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DIAGNOSIS: Please check one of the applicable diagnoses below

- ❑ Has the member been approved for Vyepti previously through the Sentara medical department?
  - ❑ Yes
  - ❑ No
- ❑ Member must be 18 years of age or older
- ❑ Prescriber has assessed baseline disease severity utilizing an objective measure/tool (e.g., International Classification of Headache Disorders (ICHD-III); Headache Impact Test [HIT-6]; monthly headache day [MHD]; Migraine Disability Assessment [MIDAS]; Migraine Physical Function Impact Diary [MPFID])
- ❑ Member has been utilizing prophylactic intervention modalities (e.g., pharmacotherapy, behavioral therapy, physical therapy, etc.)

❑ DIAGNOSIS: Episodic Migraine

- ❑ Member must have a diagnosis of frequent episodic migraines defined as at least 5 headache attacks lasting 4-72 hours (when untreated or unsuccessfully treated)
- ❑ Headaches have characteristics and symptoms consistent with migraine without aura
- ❑ Medication overuse headache has been ruled out by trial and failure of titrating off acute migraine treatments in the past
- ❑ Member must have failed at least an 8-week trial of any two oral medications for the prevention of migraines (e.g. antidepressants, beta blockers, antiepileptics) prior to initiation of Vyepti ™
  - ❑ Member had an inadequate response (or unable to tolerate) a minimum trial of at least two preferred self-injectable CGRP options:
    - ❑ Aimovig ™
    - ❑ Ajovy®
    - ❑ Emgality™ Pen
  - ❑ Vyepti not be used in combination with prophylactic calcitonin gene-related peptide (CGRP) inhibitors (e.g., Aimovig, Ajovy, Emgality, Nurtec, Qulipta, etc.)

❑ DIAGNOSIS: Chronic Migraine

- ❑ Member must have a diagnosis of chronic migraines defined as 15 or more headache (tension-type-like and/or migraine-like) days per month for > 3 months
- ❑ Member has had at least five attacks with features consistent with migraine (with and/or without aura)
- ❑ On at least 8 days per month for > 3 months:
  - ❑ Headaches have characteristics and symptoms consistent with migraine **OR**
  - ❑ Member suspected migraines are relieved by a triptan or ergot derivative medication

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- ❑ Member has failed at least an 8-week trial of any two oral medications for the prevention of migraines (e.g. antidepressants, beta blockers, antiepileptics) prior to initiation of Vyepti ™
- ❑ Member had an inadequate response (or unable to tolerate) a minimum trial of at least two preferred self- injectable CGRP options:
  - ❑ Aimovig ™
  - ❑ Ajovy®
  - ❑ Emgality™ Pen
- ❑ Vyepti will not be used in combination with prophylactic calcitonin gene-related peptide (CGRP) inhibitors (e.g., Aimovig, Ajovy, Emgality, Nurtec, Qulipta, etc.)

Reauthorization Approval: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet the initial criteria
- ❑ Member has absence of unacceptable toxicity from the drug
- ❑ 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 member-reported outcome measures:
    - ❑ Reduction of ≥ 5 points when baseline score is 11–20 OR Reduction of ≥ 30%when baseline score is > 20 in the MIDAS (Migraine Disability Assessment) scores; **OR**
    - ❑ Reduction of ≥ 5 points in the MPFID (Migraine Physical Function Impact Diary) score; **OR**
    - ❑ Reduction of ≥ 5 points in the HIT-6 (Headache Impact Test) score

Medication being provided by Specialty Pharmacy - PropriumRx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****