SENTARA HEALTH PLANS

MEDICAL 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 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Calcitonin Gene-Related Peptide (CGRP) Antagonists

Drug Requested: Vyepti™ (eptinezumab) **Intravenous (IV) Injection (Medical) (J3032)**

Sentara Considers the use of concomitant therapy with Calcitonin Gene-Related Peptide Antagonists (CGRP) and Botox to be experimental and investigational. Safety and efficacy of these combinations has not been established and will not be permitted. In the event a member has an active Botox authorization on file, all subsequent CGRP requests will not be approved.

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

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

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❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

(**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: 3 months

❑ Member must be 18 years of age or older

AND

❑ The prescribing physician is a neurologist or pain specialist **OR** has consulted with a neurologist or pain specialist;

DIAGNOSIS: Please check one of the applicable diagnoses below
❑ **Episodic Migraine.** 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 must have a diagnosis of episodic migraines defined by **BOTH** of the following:

- ❑ Member has < 15 headache days per month **AND** 4 to 14 migraine days per month for a **minimum of 3 months**;

AND

- ❑ Member must have failed a **2-month** trial of at least **TWO** migraine prophylactic classes supported by the American Headache Society/American Academy of Neurology treatment guidelines 2012/2015, Level A and B evidence; ICSI 2013, high quality evidence:
  - ❑ Anticonvulsants (divalproex, valproate, topiramate)
  - ❑ Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
  - ❑ Antidepressants (amitriptyline, venlafaxine)

AND

❑ Member must have failed a **3-month** trial of at least **ONE** of the following chronic migraine prophylactic therapies and documented the reason for failing treatment in chart notes:

- ❑ Aimovig (erenumab)
- ❑ Emgality (galcanezumab)
- ❑ Ajovy (fremanezumab)

*Aimovig, Emgality and Ajovy require PA. Member must have tried and failed **BOTH** preferred agents and meet all PA criteria for approval of Ajovy.*

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❑ **Chronic Migraine.** 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 must have a diagnosis of chronic migraines defined by **BOTH** of the following:
  - ❑ Member has > 15 headache days per month AND > 8 migraine days per month for a **minimum of 3 months**;

AND

  - ❑ Member must have failed a **2-month** trial of at least **TWO** migraine prophylactic classes supported by the American Headache Society/American Academy of Neurology treatment guidelines 2012/2015, Level A and B evidence; ICSI 2013, high quality evidence:
    - ❑ Anticonvulsants (divalproex, valproate, topiramate)
    - ❑ Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
    - ❑ Antidepressants (amitriptyline, venlafaxine)

AND

- ❑ Member must have failed a **3-month** trial of at least **ONE** of the following chronic migraine prophylactic therapies and documented the reason for failing treatment in chart notes:
  - ❑ Aimovig (erenumab)
  - ❑ Emgality (galcanezumab)
  - ❑ Ajovy (fremanezumab)

  *Aimovig, Emgality and Ajovy require PA. Member must have tried and failed **BOTH** preferred agents and meet all PA criteria for approval of Ajovy.*

❑ **For Both Episodic Migraine and Chronic Migraine:** 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 has been evaluated for medication overuse headache (MOH) (defined as headaches occurring greater than or equal to 15 days per month. It develops as a consequence of regular overuse of acute or symptomatic headache medication for more than 3 months)

AND

- ❑ Treatment will include a plan to taper off the offending medication if MOH is diagnosed;

AND

- ❑ The member will not be initiating botulinum toxin headache prophylaxis after starting the requested agent

AND

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- ❑ The requested medication will **NOT** be used in combination with Botox or another CGRP inhibitor or antagonist [e.g., Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab), Nurtec ODT (rimegepant), and Ubrelvy (ubrogepant)]

❑ **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.

- ❑ The prescribing physician is a neurologist or pain specialist **OR** has consulted with a neurologist or pain specialist;

AND

- ❑ Member has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

- ❑ Use of acute migraine medications (e.g., NSAIDs, triptans) has decreased since the start of CGRP inhibitor or antagonist therapy

AND

- ❑ The member will not be initiating botulinum toxin headache prophylaxis after starting the requested agent

AND

- ❑ The member continues to be monitored for medication overuse headache (MOH)

AND

- ❑ The requested medication will **NOT** be used in combination with Botox or another CGRP inhibitor or antagonist [e.g., Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab), Nurtec ODT (rimegepant), and Ubrelvy (ubrogepant)].

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

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.

***Approved by Pharmacy and Therapeutics Committee**: 6/18/2020
REVISED/UPDATED: ~~9/10/2020;~~ **11/13/2020;**