OKLAHOMA Health Care Authority

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 Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.
Page 1 of 2—Please complete and return all pages. *Failure to complete all pages will result in processing delays*.

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

1. What is the member's diagnosis?
   - ❑ Preventative 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. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated?
   a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes☐ No☐
   b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes☐ No☐
7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated?
   a. Hormone replacement therapy or hormone-based contraceptives? Yes☐ No☐
   b. Chronic insomnia? Yes☐ No☐
   c. Obstructive sleep apnea? Yes☐ No☐
8. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes☐ No☐ If yes, please list:
   Medication_____ Date Span_____ Dosing_____
   Medication_____ Date Span_____ Dosing_____
   Medication_____ Date Span_____ Dosing_____
9. If the trial duration for the medication(s) listed above is not a least 8 weeks, please document the reason(s):
   Medication(s)_____
   Reason(s) for discontinuation prior to 8 weeks: _____
10. Is the member taking any of the following medications **known** to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain?
    a. Decongestants (alone or in combination products)? Yes☐ No☐
    b. Combination analgesics containing caffeine and/or butalbital? Yes☐ No☐
    c. Opioid-containing medications? Yes☐ No☐
    d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes☐ No☐
    e. Ergotamine-containing medications? Yes☐ No☐
    f. Triptans? Yes☐ No☐

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
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Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Criteria

All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.
Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization (continued):

11. Is the member taking any of the medications, listed in Question 10., **known** to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain?
    a. If yes, to any of the medication(s) listed in Question 10., please list the medication(s) and the number of days per month taken: _____
    _____
    b. If yes, to any of the medication(s) listed in Question 10., please provide additional information to support member's need for continued use of medication(s) known to cause overuse or rebound headaches:
    _____
    _____
12. Is the member taking any medications that are **likely** to be the cause of the headaches? Yes ☐ No ☐
13. Has the member been evaluated within the last six months by a neurologist for migraine headaches and was Vyepti® recommended as treatment? Yes ☐ No ☐
    a. If yes, please include name of neurologist recommending Vyepti® treatment _____
14. 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 ☐
15. If applicable, are other aggravating factors that contribute to the development of episodic/chronic migraine headaches being treated (e.g., smoking)? Yes ☐ No ☐ Not Applicable ☐
16. Will Vyepti® be prepared and administered according the Vyepti® *Prescribing Information*? Yes ☐ No ☐
17. Please provide a patient-specific, clinically significant reason why the member cannot use Emgality® (galcanezumab-gnlm) or Ajovy® (fremanezumab-vfrm):
    _____
    _____
18. If the maximum recommended dosing (300mg every 3 months) for Vyepti® is being requested, please provide a patient-specific, clinically significant reason why other available CGRP inhibitors for migraine prophylaxis are not appropriate for this member: _____
    _____

For Continued Authorization (Compliance and information regarding efficacy will be required for continued approval):

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

Additional Information: _____
_____

Please complete and return all pages. Failure to complete all pages will result in processing delays.

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.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*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.*