AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

Antimigraine Agents, Vyepti® (eptinezumab-jmmr)

Fax back to: 1-855-799-2553

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/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

Preventive treatment of migraine	
Preferred Agents step edit and PA required	**Non-Preferred Agents (PA required)**
Aimovig®, Ajovy® and Ajovy® autoinjector, Emgality® pen and syringe (120 mg), Nurtec® ODT, Qulipta™	Emgality® syringe (100 mg), Vyepti®
Acute treatment of migraine	
Preferred Agents (No PA with trial of 2 generic triptans)	**Non-Preferred Agents (PA required)**
Nurtec® ODT, Ubrelvy™	Reyvow®, Zavzpret™

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

Identify why the preferred agents cannot be used.

DIAGNOSIS AND MEDICAL INFORMATION

All drugs in this class are eligible to receive a SIX (6)-month approval. Complete the following questions. For preventive treatment of migraine, does the member meet the step edit AND the following criteria?

1. Has the prescriber 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])? **AND**

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

3. Has the member been utilizing prophylactic intervention modalities (e.g., 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 > 3 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 8 days per month for > 3 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 8-week trial of any two oral medications for the prevention of migraines (e.g 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

5. Does the member have diagnosis of frequent episodic migraines defined as at least 5 headache attacks lasting 4–72 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

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

6. Will Vyepti not be used in combination with prophylactic calcitonin gene-related peptide (CGRP) inhibitors? (e.g., erenumab, galcanezumab, fremanezumab, atogepant, rimegepant, etc.)

   ☐ Yes ☐ No

For renewal, complete the following question to receive a TWELVE (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 11–20 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.