Print Reset

United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

Antimigraine Agents, Vyepti® (eptinezumab-jmmr)

If the following information is not complete, correct, or legible, the SA 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 required	**Non-Preferred Agents (SA 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 SA with trial of 2 generic triptans)	**Non-Preferred Agents (SA required)**
Nurtec® ODT, Ubrelvy™	Reyvow®, Trudhesa™, 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. Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria? **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 SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826