HEALTH PLANS
UNIVERSITY OF UTAH

MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM
VYEPTI™

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: Healthy U: 833-981-0212, Individual Exchange: 833-981-0214, Commercial Groups: 833-981-0213, MHC: 844-262-1560, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Vyepti™ (eptinezumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of episodic or chronic migraines?	☐	☐	**Please provide documentation**
2. Has the member has a 3-month trial and failure, contraindication, or intolerance to a beta-blocker and at least 1 of the following: • A calcium channel blocker • An antidepressant • An anticonvulsant • Botulinum toxin type A at least 12 weeks apart • An angiotensin-converting enzyme (ACE) inhibitor Note: if the member cannot try a beta-blocker, then 2 migraine prevention medication classes listed above must be tried.	☐	☐	**Please provide documentation**
3. Has the member tried and failed, or is contraindicated to, both preferred agents Ajovy® and Emgality®?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does clinical documentation show a positive response to therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy: PHARM-M032
Origination Date: 09/18/2020
Reviewed/Revised Date: 10/28/2020
Next Review Date: 10/28/2021
Current Effective Date: 11/01/2020