HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
VYEPTI™

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

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, Botulinum toxin type A, and at least 1 of the following: • A calcium channel blocker • An antidepressant • An anticonvulsant • 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, preferred agents Ajovy®, Emgality®, and Aimovig®?	☐	☐	**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:

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Policy: PHARM-CHIP-M032
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024