



MEDICARE FORM

Vyepti® (eptinezumab-jjmr) Injectable Medication Precertification Request

Page 1 of 3

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Vyepti is non-preferred. The preferred products are Aimovig and Qulipta.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For Aetna Medicare Advantage and **Allina Health Aetna Medicare Members** send request to:

Phone: [1-866-503-0857](tel:1-866-503-0857) (TTY: [711](tel:1-866-503-0857))

Fax: [1-844-268-7263](tel:1-844-268-7263)

Availity: <https://www.aetna.com/health-care-professionals/resource-center/availability.html>

For Aetna Medicare FIDE (HMO-DSNP) **Virginia Dual Eligible Special Needs Plans** send request to:

Phone: [1-855-463-0933](tel:1-855-463-0933)

Fax: [1-833-280-5224](tel:1-833-280-5224)

Availity: <https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal>

For Aetna Medicare FIDE (HMO-DSNP) **New Jersey Dual Eligible Special Needs Plans** send request to:

Phone: [1-844-362-0934](tel:1-844-362-0934)

Fax: [1-833-322-0034](tel:1-833-322-0034)

Availity: <https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html>

For Aetna Medicare FIDE (HMO D-SNP) **Illinois Dual Eligible Special Needs Plans** send request to:

Phone: [1-866-600-2139](tel:1-866-600-2139)

FAX: [1-855-320-8445](tel:1-855-320-8445)

Availity: <https://www.aetnabetterhealth.com/illinois/providers/portal>

For Aetna Medicare HIDE (HMO D-SNP) **Michigan Dual Eligible Special Needs Plans** send request to:

Phone: [1-855-676-5772](tel:1-855-676-5772)

Fax: [1-844-241-2495](tel:1-844-241-2495)

Availity: <https://www.aetnabetterhealth.com/michigan/providers/portal.html>



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Note: Vyepti is non-preferred. The preferred products are Aimovig and Qulipta.

Please indicate: Start of treatment: Start date ____ / ____ / ____
 Continuation of therapy: Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

| | | | | | |
|--------------------------------------|-------------|---------------------------------|--|------------|------|
| First Name: | | Last Name: | | DOB: | |
| Address: | | City: | | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | | E-mail: | |
| Current Weight: ____ lbs or ____ kgs | | Height: ____ inches or ____ cms | | Allergies: | |

B. INSURANCE INFORMATION

| | |
|--------------------------|--|
| Aetna Member ID #: _____ | Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Group #: _____ | If yes, provide ID#: _____ Carrier Name: _____ |
| Insured: _____ | Insured: _____ |

C. PRESCRIBER INFORMATION

| | | | | | |
|------------------|------|----------------------|--------|--|-------|
| First Name: | | Last Name: | | (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A. | |
| Address: | | City: | | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider E-mail: | | Office Contact Name: | | Phone: | |

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

| | |
|---|---|
| Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ Address: _____ NPI: _____ | Dispensing Provider/Pharmacy: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____ |
|---|---|

E. PRODUCT INFORMATION

Request is for: Vyepti (eptinezumab-jjmr): HCPCS Code: _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

Note: Vyepti (eptinezumab-jjmr) is non-preferred. The preferred products are Aimovig (erenumab) and Qulipta (atogepant).

Yes No Has the patient received a dose of Vyepti (eptinezumab-jjmr) through insurance in the past 365 days?
This does not include samples or doses administered without prior authorization.

No Has the patient had a documented inadequate response to both of the following preferred products ? (if yes, select all that apply below)
Medical records (e.g., chart notes) documenting an inadequate response to a trial of both preferred products must be available upon request.

Aimovig (erenumab) Qulipta (atogepant)

→ When was the member's inadequate response to the preferred drug(s)? _____

→ Please describe the nature of the inadequate response to the preferred drug(s) _____

No Has the patient had a documented intolerable adverse event to both of the following preferred products ? (if yes, select all that apply below)
Medical records (e.g., chart notes) documenting the patient experienced an adverse reaction to both preferred products must be available upon request.

Aimovig (erenumab) Qulipta (atogepant)

→ When was the member's intolerable adverse event to the preferred drug(s)? _____

→ Please describe the nature of the intolerable adverse event to the preferred drug(s) _____

Please explain if there are any other medical reason(s) that the patient cannot use any of the following (select all that apply)

Aimovig (erenumab) Qulipta (atogepant)

Yes No Has the patient been treated with another medication for this diagnosis?

→ Please provide the name of the previous medication(s): _____

Please provide the date range of previous treatment: ____ / ____ / ____ - ____ / ____ / ____

Continued on next page



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| | | | |
|--------------------|-------------------|---------------|-------------|
| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|--------------------|-------------------|---------------|-------------|

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

Yes No Was treatment with this medication ineffective, not tolerated, or contraindicated?
 → Please select which one applies to the previous treatment: Ineffective Not tolerated Contraindicated
 Please explain answer: _____

Yes No Has this condition been confirmed by diagnostic testing?
 → Please provide the diagnostic test name and date performed: Test name: _____ Date: ____/____/____

Please provide any relevant laboratory data specific to this drug request
 (e.g. complete blood count, liver transaminase, bilirubin, TB testing, pregnancy test, genetic testing):
 Name of test(s): _____
 Test results: _____
 Date(s) of testing: _____

Please list any other relevant information specific to this medication request:

What classification of headache is the patient using the requested medication for?
 Please select: Chronic migraines Episodic migraines Other
 Yes No Does the patient have at least 15 to 26 headache days per month?
 → Yes No Does the patient have at least 4 to 14 headache days per month?
 → Yes No Were at least 4 of those migraine days?
 → Yes No Were at least 8 of those migraine days?

For Continuation of Therapy: (clinical documentation required):

Yes No Is the patient receiving benefit from therapy with the requested medication, which is defined as a reduction in migraine days per month from baseline?

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.