

State of Oklahoma SoonerCare

Vyepti[®] (Eptinezumab-jjmr) Prior Authorization Form

treated? a. Hormone replacement therapy or hormone-based contraceptives? YesNo b. Chronic insomnia? YesNo c. Obstructive sleep apnea? YesNo 8. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? YesNo If yes, please list: Medication Date Span Dosing	Member Name:		Date of Birt	th:	Member ID#:
Billing Provider Information Provider NPI:			Drug Info	rmation	
Provider NPI:	Pha	rmacy billing (NDC:) Physician bil	lling (HCPCS code:	:) Dose:
Provider NPI:	• • •			• ,	
Provider NPI:			Billing Provide	er Information	
Prescriber NPI:	Pro	vider NPI:			
Prescriber NPI:					
Prescriber NPI:					
All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval. **Page 1 of 2—Please complete and return all pages. *Failure to complete all pages will result in processing delays.** For Initial Authorization (Initial approval will be for the duration of 3 months): 1. What is the member's diagnosis? Preventative treatment of migraines in adults Preventative treatment of migraines in adults Other, please list: Chronic Migraine Headache Episodic Migraine Episodic Migraine Headache Episodic Migraine Headach	Pres	scriber NPI:			
All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval. "Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays." For Initial Authorization (Initial approval will be for the duration of 3 months): 1. What is the member's diagnosis? Preventative treatment of migraines in adults Other, please list: Does the member have documented: Chronic Migraine Headache Episodic Migraine Headache Episodic Migraine Headache Episodic Migraine Headache Episodic Migraine delagnosis? Number of headache days per month? Number of headache days per month (if episodic migraine, number of days on average for the past 3 months)? Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated? a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes No b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear ter traumal? Yes No Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear fer traumal? Yes No b. Chronic insomnia? Yes No No If yes, please list: No No If yes, please list: No No If yes, please list: No No Medication Date Span Dosing Dosing Dosing Dosing Dosing Medication Date Span Dosing Dosing Medication Date Span Dosing Dosing Medication Date Span Dosing Medicat					
All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval. "Page 1 of 2 —Please complete and return all pages. Failure to complete all pages will result in processing delays.* For Initial Authorization (Initial approval will be for the duration of 3 months): 1. What is the member's diagnosis? Preventative treatment of migraines in adults Other, please list: Does the member have documented: Chronic Migraine Headache Episodic Migraine Headache Date of member's migraine diagnosis? Number of headache days per month? Number of fingraine days per month (if episodic migraine, number of days on average for the past 3 months)? Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated? a. Increased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? YesNo Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? YesNo A Hormone replacement therapy or hormone-based contraceptives? YesNo a. Hormone replacement therapy or hormone-based contraceptives? YesNo b. Chronic insomnia? YesNo c. Obstructive sleep apnea? YesNo b. Chronic insomnia? YesNo Medication			<u> </u>		
The member's drug history will be reviewed prior to approval. *Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.* For Initial Authorization (Initial approval will be for the duration of 3 months): 1. What is the member's diagnosis? Preventative treatment of migraines in adults Other, please list: Does the member have documented: Chronic Migraine Headache Episodic Migraine Headache Episodic Migraine Headache Date of member's migraine diagnosis? Number of headache days per month? Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? Number of headache days per month (if episodic migraine, number of days on average for the past 3 months)? Number of headache exacerbation secondary to the following medication therous thrombosis)? Yes No No Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No No Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No No Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No No Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No Decreased intracranial pressure (e.g., post-lumbar puncture headache of traumal? Yes No No Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No Decreased intracranial pressure (e.g., post-lumbar puncture headache are after trauma)? Yes No Decreased intracranial pressure (e.g., post-lumbar puncture headache exacerbations headache exacerbation sent	ΛII :	information must be r			urther requested decumentation
Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays. For Initial Authorization (Initial approval will be for the duration of 3 months): What is the member's diagnosis? Preventative treatment of migraines in adults Other, please list: Chronic Migraine Headache Episodic Migraine Headache Episodic Migraine Headache Episodic Migraine Headache Episodic Migraine days per month? Number of headache days per month (if episodic migraine, number of days on average for the past 3 months)? Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? Number of ineadache days per month (if episodic migraine, number of days on average for the past 3 months)? Number of migraine days per month? Number of migraine bear unded of the following medical conditions thrombosis)? Yes No No Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No No No No No No No N					ittier requested documentation.
1. What is the member's diagnosis? ☐ Preventative treatment of migraines in adults ☐ Other, please list: 2. Does the member have documented: ☐ Chronic Migraine Headache ☐ Episodic Migraine Headache ☐ Episodic Migraine Headache ☐ Date of member's migraine diagnosis? ☐ Number of headache days per month (if episodic migraine, number of days on average for the past 3 months)? ☐ Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? ☐ Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated? ☐ Increased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No ☐ B. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No ☐ Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated? ☐ Alformone replacement therapy or hormone-based contraceptives? Yes No ☐ Cobstructive sleep apnea? Yes No ☐ Date Span No ☐ Date Span Dosing ☐ Medication Dosing Dosing ☐ Date Span Dosing ☐ Dosing ☐ Medication For the medication(s) listed above is not a least 8 weeks, please document the reason(s): ☐ Medication(s) Reason(s) for discontinuation prior to 8 weeks: ☐ Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? ☐ a. Decongestants (alone or in combination products)? Yes No ☐ Copioid-containing medications? Yes No ☐ Copioid-containing medications? Yes No ☐ Firiptans? Yes No ☐ Rage 1 of 2					es will result in processing delays.*
Preventative treatment of migraines in adults Other, please list:				duration of 3 mor	nths):
□ Other, please list: 2. Does the member have documented: □ Chronic Migraine Headache □ Episodic Migraine Headache 3. Date of member's migraine diagnosis? 4. Number of headache days per month? 5. Number of migraine days per month? 6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated? a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes No b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated? a. Hormone replacement therapy or hormone-based contraceptives? Yes No b. Chronic insomnia? Yes No c. Obstructive sleep apnea? Yes No c. Obstructive sleep apnea? Yes No Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes No Medication Date Span Dosing Medication(s) Reason(s) for discontinuation prior to 8 weeks: 10. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No b. Combination analgesics containing caffeine and/or butalbital? Yes No c. Opioid-containing medications? Yes No d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No e. Ergotamine-containing medications? Yes No e. Ergotamine-containing medications? Yes No Fage 1 of 2	1. \		•		·
2. Does the member have documented:					
□ Chronic Migraine Headache □ Episodic Migraine Headache 3. Date of member's migraine diagnosis? 4. Number of headache days per month? 5. Number of higraine days per month! (if episodic migraine, number of days on average for the past 3 months)? 6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated? 6. a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes No b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No b. Chronic insomnia? Yes No treated? 6. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated? 7. a. Hormone replacement therapy or hormone-based contraceptives? Yes No b. Chronic insomnia? Yes No c. Obstructive sleep apnea? Yes No lf yes, please list: Medication antidepressants, etc)? Yes No If yes, please list: Medication Dosing Dosing Medication Dosing Medication Dosing Dosing Medication Dosing Dosing No Span Dosing No Span Dosing No Season(s) for discontinuation prior to 8 weeks: 10. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pains? a. Decongestants (alone or in combination products)? Yes No c. Opioid-containing medications? Yes No c. Opioid-containing medications? Yes No c. Opioid-containing medications? Yes No c. Ergotamine-containing medications? Yes No c. Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2					
Date of member's migraine diagnosis? 4. Number of headache days per month? 5. Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? 6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated? a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes No b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No treated? 7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated? 8. Hormone replacement therapy or hormone-based contraceptives? Yes No b. Chronic insomnia? Yes No c. Obstructive sleep apnea? Yes No lf yes, please list: Medication Date Span Dosing Medication(s) Date Span Dosing Medication(s) Season(s) for discontinuation prior to 8 weeks: 10. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No b. Combination analgesics containing caffeine and/or butalibital? Yes No c. Opioid-containing medications? Yes No b. Combination analgesics containing medications? Yes No c. Ergotamine-containing medications? Yes No c Page 1 of 2	2. I	Does the member have d	ocumented:		
Date of member's migraine diagnosis? 4. Number of headache days per month? 5. Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? 6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated? a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes No b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No treated? 7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated? 8. Hormone replacement therapy or hormone-based contraceptives? Yes No b. Chronic insomnia? Yes No c. Obstructive sleep apnea? Yes No lf yes, please list: Medication Date Span Dosing Medication(s) Date Span Dosing Medication(s) Season(s) for discontinuation prior to 8 weeks: 10. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No b. Combination analgesics containing caffeine and/or butalibital? Yes No c. Opioid-containing medications? Yes No b. Combination analgesics containing medications? Yes No c. Ergotamine-containing medications? Yes No c Page 1 of 2		Chronic Migraine	Headache		
3. Date of member's migraine diagnosis? 4. Number of headache days per month? 5. Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? 6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated? 7. a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? YesNo_ 7. b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? YesNo_ 7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated? 7. a. Hormone replacement therapy or hormone-based contraceptives? YesNo 7. b. Chronic insomnia? YesNo 8. Las the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? YesNo If yes, please list: Medication Date Span Dosing Medication Date Span Dosing Medication Date Span Dosing Medication Date Span Dosing		☐ Episodic Migraine	e Headache		
4. Number of headache days per month? 5. Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? 6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated? a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes No b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No b. Chronia insomnia? Yes No b. Chronic insomnia? Yes No b. Chronic insomnia? Yes No c. Obstructive sleep apnea? Yes No lf yes, please list: Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes No If yes, please list: Medication Date Span Dosing Medication Date Span Dosing Medication Date Span Dosing No Span Dosing Posing No Span Dosing No Span Dosing No Season(s) for discontinuation prior to 8 weeks: 10. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No C. Opioid-containing medications? Yes No C. Opioid-containing medications? Yes No C. Opioid-containing medications? Yes No Figotamine-containing medications? Yes No C. Triptans? Yes No Fage 1 of 2	3 1				
5. Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? 6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated? a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes No b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes No 7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated? a. Hormone replacement therapy or hormone-based contraceptives? Yes No b. Chronic insomnia? Yes No c. Obstructive sleep apnea? Yes No c. Obstructive sleep apnea? Yes No b. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes No If yes, please list: Medication Date Span Dosing Medication Dosing Dosing Please in the span Dosing Dosing No Please of intractable conditions in the absence of intractable conditions where taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No C. Opioid-containing medications? Yes No C. Triptans? Yes No Page 1 of 2					
6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated? a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? YesNo b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? YesNo 7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated? a. Hormone replacement therapy or hormone-based contraceptives? YesNo c. Obstructive sleep apnea? YesNo c. Obstructive sleep apnea? YesNo large in the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? YesNo If yes, please list: Medication Date Span Dosing Medication Date Span Dosing Medication Date Span Dosing 9. If the trial duration for the medication(s) listed above is not a least 8 weeks, please document the reason(s): Medication(s) Reason(s) for discontinuation prior to 8 weeks: 10. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No b. Combination analgesics containing caffeine and/or butalbital? Yes No c. Opioid-containing medications? Yes No d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2				number of days on ave	arage for the past 3 months)?
a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? YesNo	J. 1	Have the following medic	per monti (il episodic migrame, n	vacarbata migrainas b	rage for the past 3 months):
b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? YesNo 7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated? a. Hormone replacement therapy or hormone-based contraceptives? YesNo b. Chronic insomnia? YesNo c. Obstructive sleep apnea? YesNo c. Obstructive sleep apnea? YesNo 8. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? YesNo If yes, please list: Medication Date Span Dosing Medication Date Span Dosing Medication Date Span Dosing	0. 1	nave the following medica	an conditions known to cause of ex	cacerbate migrames b	Lyanaya thrambasia 2 Vas
7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated? a. Hormone replacement therapy or hormone-based contraceptives? Yes No b. Chronic insomnia? Yes No c. Obstructive sleep apnea? Yes No 8. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes No If yes, please list: Medication Date Span Dosing Medication Date Span Dosing Medication Date Span Dosing 9. If the trial duration for the medication(s) listed above is not a least 8 weeks, please document the reason(s): Medication(s) Reason(s) for discontinuation prior to 8 weeks: 10. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No b. Combination analgesics containing caffeine and/or butalbital? Yes No c. Opioid-containing medications? Yes No d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2					
treated? a. Hormone replacement therapy or hormone-based contraceptives? YesNo b. Chronic insomnia? YesNo c. Obstructive sleep apnea? YesNo 8. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? YesNo If yes, please list: Medication Date Span Dosing	-				
a. Hormone replacement therapy or hormone-based contraceptives? YesNo b. Chronic insomnia? YesNo c. Obstructive sleep apnea? YesNo 8. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? YesNo If yes, please list: Medication Date Span Dosing Medication Date Span Dosing			xacerbation secondary to the folio	owing medication thera	apies or conditions been ruled out and/or
b. Chronic insomnia? Yes No C. Obstructive sleep apnea? Yes No Sleep apnea? Yes No If yes, please list: **No If yes, please list:** **Medication Date Span Dosing Medication Dosing Medication Date Span Dosing Dosing Medication(s) Medication for the medication(s) listed above is not a least 8 weeks, please document the reason(s): **Medication(s) Reason(s) for discontinuation prior to 8 weeks: 10	1				
c. Obstructive sleep apnea? Yes No 8. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes No If yes, please list: Medication Date Span Dosing Medication Date Span Dosing Medication Date Span Dosing Medication Dosing Dosing Dosing Span Dosing				contraceptives? Yes	No
8. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes No If yes, please list: Medication Date Span Dosing					
anticonvulsants, antidepressants, etc)? Yes No If yes, please list: Medication Date Span Dosing		c. Obstructive sleep			and an above the second control of the secon
Medication					migraine prevention (antinypertensives,
9. If the trial duration for the medication(s) listed above is not a least 8 weeks, please document the reason(s): Medication(s) Reason(s) for discontinuation prior to 8 weeks: 10. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No b. Combination analgesics containing caffeine and/or butalbital? Yes No c. Opioid-containing medications? Yes No d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No e. Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2	ć	anticonvuisants, antidepre	essants, etc)? Yes No II	r yes, piease list:	Desire
9. If the trial duration for the medication(s) listed above is not a least 8 weeks, please document the reason(s): Medication(s) Reason(s) for discontinuation prior to 8 weeks: 10. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No b. Combination analgesics containing caffeine and/or butalbital? Yes No c. Opioid-containing medications? Yes No d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No e. Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2		Medication	Date 3	span	Dosing
 If the trial duration for the medication(s) listed above is not a least 8 weeks, please document the reason(s): Medication(s)		Medication	Date 3	Span	Dosing
Medication(s) Reason(s) for discontinuation prior to 8 weeks: 10. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No b. Combination analgesics containing caffeine and/or butalbital? Yes No c. Opioid-containing medications? Yes No d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No e. Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2	0 1	If the trial duration for the	modication(s) listed above is not	a loact 9 wooks, place	Dosing
Reason(s) for discontinuation prior to 8 weeks: 10. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No b. Combination analgesics containing caffeine and/or butalbital? Yes No c. Opioid-containing medications? Yes No d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No e. Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2			medication(s) listed above is not a	a least o weeks, pieas	e document the reason(s).
 10. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No b. Combination analgesics containing caffeine and/or butalbital? Yes No c. Opioid-containing medications? Yes No d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No e. Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2 		Posson(s) for discontinue	ation prior to 9 wooks:		
absence of intractable conditions known to cause chronic pain? a. Decongestants (alone or in combination products)? Yes No b. Combination analgesics containing caffeine and/or butalbital? Yes No c. Opioid-containing medications? Yes No d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No e. Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2	10	le the member taking any	of the following medications know	un to cause medication	n overuse or rehound headaches in the
a. Decongestants (alone or in combination products)? Yes No b. Combination analgesics containing caffeine and/or butalbital? Yes No c. Opioid-containing medications? Yes No_ d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No_ e. Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2					if overuse of repound fleadacties in the
b. Combination analgesics containing caffeine and/or butalbital? Yes No c. Opioid-containing medications? Yes No d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No e. Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2	•				
c. Opioid-containing medications? YesNo d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No e. Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2		b Combination and	lacsics containing caffeine and/or	hutalhital? Vec N	do.
d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No e. Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2		o. Opioid containing	modications? Voc.	butaibital: 1esi	10
e. Ergotamine-containing medications? Yes No f. Triptans? Yes No Page 1 of 2		d Analgesis modica	tions including acetaminaphen or	non-steroidal anti infl	ammatory druge (NSAIDe)2 Voc. No.
f. Triptans? YesNo Page 1 of 2					animatory drugs (NOAIDS): 165 NO
rage 1 012		f Triptons? Voc	No		
		i. Tilptalis! 165	Page	1 of 2	
	PLE/	ASE PROVIDE THE INFORMA	TION REQUESTED AND RETURN TO:		CONFIDENTIALITY NOTICE

University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit

> Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.



State of Oklahoma SoonerCare

Vyepti[®] (Eptinezumab-jjmr) Prior Authorization Form

Mε	ember l	Name:	Date of Birth:	Member ID#:			
			Criteria				
Th	e mem	ber's drug history will be re	nd SoonerCare may verify throu eviewed prior to approval.	igh further requested documentation.			
	Is the n	ches in the absence of intractable	cations, listed in Question 10., known le conditions known to cause chronic	to cause medication overuse or rebound c pain? the medication(s) and the number of days			
	b.		n(s) listed in Question 10., please pro use of medication(s) known to cause	ovide additional information to support eoveruse or rebound headaches:			
13. 14. 15. 16.	2. Is the member taking any medications that are likely to be the cause of the headaches? Yes No 3. Has the member been evaluated within the last six months by a neurologist for migraine headaches and was Vyepti® recommended as treatment? Yes No a. If yes, please include name of neurologist recommending Vyepti® treatment 4. Will member use Vyepti® concurrently with botulinum toxin for the prevention of migraine or with an alternative calcitonin gene-related peptide (CGRP) inhibitor? Yes No 5. If applicable, are other aggravating factors that contribute to the development of episodic/chronic migraine headaches being treated (e.g., smoking)? Yes No Not Applicable 6. Will Vyepti® be prepared and administered according the Vyepti® <i>Prescribing Information</i> ? Yes No 7. Please provide a patient-specific, clinically significant reason why the member cannot use Emgality® (galcanezumabgnlm) or Ajovy® (fremanezumab-vfrm):						
18.		c, clinically significant reason wh		is being requested, please provide a patient- or migraine prophylaxis are not appropriate for			
co 1. 2. 3.	ntinued Has the Has the Please	d approval): e member been compliant with very member responded well to tree provide the member's current responded.	liance and information regarding Vyepti [®] (eptinezumab-jjmr) treatment with Vyepti [®] (eptinezumab-jjmumber of migraine days per month:	t? Yes No mr)? Yes No			
Page 2 of 2 Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.							
Prescriber Signature:				te:			
l c e Ple	ertify tha	t the indicated treatment is medi- ot send in chart notes. Specific info	ically necessary and all information is	true and correct to the best of my knowledge. Failure to complete this form in full will result in			

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit

> Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.