BlueCross BlueShield of North Carolina

eptinezumab-jjmr (Vyepti™)

INTRAVENOUS INFUSION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

PRIOR REVIEW/CERTIFICATION REQUEST FOR SERVICES FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility #, Tax ID # or NPI**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #			
PLACE OF SERVICE: ☐ Home ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy			
Specialty Pharmacy:		**Specialty Pharmacy NPI:**	
HCPCS CODE: ☐ J3032		**CPT/Other billing code:**	
Primary Diagnosis:		**ICD-10:**	
Drug Requested:			
Strength & Route of Administration:			

Please answer the following questions for <u>INITIAL</u> coverage:

***See pages 3-4 for continuation coverage ***

1. Is the patient 18 years of age or older?.....☐ Yes ☐ No
2. Does the patient have a diagnosis of **chronic migraine**?.....☐ Yes ☐ No
   a. **If YES,** over the last 3 months, has the patient experienced any of the following:
      i. Greater than or equal to 15 headache days per month?.....☐ Yes ☐ No
      ii. Greater than or equal to 8 migraine days per month?.....☐ Yes ☐ No
3. Does the patient have a diagnosis of **episodic migraine**?.....☐ Yes ☐ No
   a. **If YES,** over the last 3 months, has the patient experienced any of the following:
      i. Less than or equal to 14 headache days per month, of which at least 4 are migraine days?.....☐ Yes ☐ No
      ii. Migraine attacks that are attributed to a diminished quality of life despite the use of acute rescue medications?.....☐ Yes ☐ No
      iii. Contraindications to acute therapies?.....☐ Yes ☐ No
      iv. Inadequate response to acute therapies?.....☐ Yes ☐ No
      v. Serious side effects to acute therapies?.....☐ Yes ☐ No
      vi. Risk of medication overuse headache without preventative therapy?.....☐ Yes ☐ No

continued on page 2; sign page 2 for prior authorization request

eptinezumab-jjmr (Vyepti™) - *continued*

4. Has the patient had an adequate trial (4-6 weeks) and was adherent to any of the following migraine prophylaxis treatment options (**medical record documentation required**):
   a. Beta blockers?.....☐ Yes ☐ No
   b. Antidepressants?.....☐ Yes ☐ No
   c. Anticonvulsants?.....☐ Yes ☐ No

5. Does the patient have a clinical contraindication or intolerance to **ALL** of the following migraine prophylaxis treatment options: beta blockers, antidepressants, anticonvulsants?.....☐ Yes ☐ No
   If YES, please submit medical record documentation.

6. Has the patient tried and had an inadequate response to any of the following medications (**medical record documentation required**):
   a. Aimovig (erenumab)?.....☐ Yes ☐ No
   b. Emgality (galcanezumab)?.....☐ Yes ☐ No
   c. Ajovy (fremanezumab)?.....☐ Yes ☐ No

7. Does the patient have a clinical contraindication or intolerance to any of the following that is not expected to occur with the requested medication (**medical record documentation required**):
   a. Aimovig (erenumab)?.....☐ Yes ☐ No
   b. Emgality (galcanezumab)?.....☐ Yes ☐ No
   c. Ajovy (fremanezumab)?.....☐ Yes ☐ No

8. Has the patient been treated with a botulinum toxin agent in the past four months, or will they be taking with the requested medication, for migraine prophylaxis?.....☐ Yes ☐ No
   Please note: if approved for the requested medication, any previous authorization through Blue Cross NC for botulinum toxin used for migraine prophylaxis will be terminated.

9. Is the patient currently taking another calcitonin gene-related peptide (CGRP) receptor antagonist indicated for migraine prophylaxis (e.g., erenumab, fremanezumab, galcanezumab)?.....☐ Yes ☐ No
   a. **If YES**, will the patient discontinue use of the other CGRP prior to starting the requested medication?.....☐ Yes ☐ No

10. Does the patient have other reasons to explain headache/migraine frequency including history of cardiovascular disease (hypertension, ischemic heart disease), neurological disease, or cerebrovascular disease?.....☐ Yes ☐ No

11. Will the injection or infusion of the requested medication be administered in an **inpatient or outpatient hospital setting**?.....☐ Yes ☐ No
    If YES, please answer the Site of Care questions on pages 5-6.

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-888-348-7332

BlueCross BlueShield of North Carolina

eptinezumab-jjmr (Vyepti™) - CONTINUATION

INTRAVENOUS INFUSION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

PRIOR REVIEW/CERTIFICATION REQUEST FOR SERVICES FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility #, Tax ID # or NPI**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #			

PLACE OF SERVICE: ☐ Home ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy	
Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE: ☐ J3032	**CPT/Other billing code:**
Primary Diagnosis:	**ICD-10:**
Drug Requested:	
Strength & Route of Administration:	

Please answer the following questions for <u>CONTINUATION</u> coverage:

12. Was the patient approved for initial coverage for the requested medication through Blue Cross NC?.....☐ Yes ☐ No
    If NO, please answer all questions on pages 1-2.
13. Is the patient using the requested medication for the prevention of migraine?.....☐ Yes ☐ No
14. Is the request for eptinezumab (Vyepti) 100mg strength dosing?.....☐ Yes ☐ No
    If YES, please answer the following questions:
    a. Has the patient had a positive clinical response with the requested medication, demonstrated by a decrease from baseline in the number of migraine days per month or migraine frequency?.....☐ Yes ☐ No
       If YES, please submit medical record documentation.
    b. Has the patient experienced a reduction in the need for migraine rescue medications (i.e., NSAIDs, triptans, ergot derivatives)?.....☐ Yes ☐ No

****continued on page 4; sign page 4 for prior authorization request****

eptinezumab-jjmr (Vyepti™) - *continued*

15. Is the request for eptinezumab (Vyepti) 300mg strength dosing?.....☐ Yes ☐ No
    If YES, please answer the following questions:
    a. Has the patient had an adequate trial (at least 3 months) to the 100mg strength dose and had an inadequate response?.....☐ Yes ☐ No
       If YES, please submit medical record documentation.
    b. Was the patient previously approved for the 300mg strength dose through Blue Cross NC?.....☐ Yes ☐ No
       If YES, please answer the following questions:
       i. Has the patient had a positive clinical response with eptinezumab (Vyepti) 300mg strength treatment, demonstrated by a decrease from baseline in the number of migraine days per month or migraine frequency?.....☐ Yes ☐ No
          If YES, please submit medical record documentation.
       ii. Has the patient experienced a reduction in the need for migraine rescue medications (i.e., NSAIDs, triptans, ergot derivatives)?.....☐ Yes ☐ No

16. Has the patient been treated with a botulinum toxin agent in the past four months, or will they be taking with the requested medication, for migraine prophylaxis?.....☐ Yes ☐ No
    Please note: if approved for the requested medication, any previous authorization through Blue Cross NC for botulinum toxin used for migraine prophylaxis will be terminated.

17. Will the patient be using another calcitonin gene-related peptide (CGRP) receptor antagonist indicated for migraine prophylaxis (e.g., erenumab, fremanezumab, galcanezumab) at the same time as the requested medication?.....☐ Yes ☐ No

18. Will the injection or infusion of the requested medication be administered in an **inpatient or outpatient hospital setting**?.....☐ Yes ☐ No
    If YES, please answer the Site of Care questions on pages 5-6.

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-888-348-7332

BlueCross BlueShield of North Carolina

eptinezumab-jjmr (Vyepti™) – SITE OF CARE

INTRAVENOUS INFUSION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility #, Tax ID # or NPI**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #			

PLACE OF SERVICE: ☐ Home ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy	
Specialty Pharmacy:	**Home infusion:**
HCPCS CODE: ☐ J3032	**CPT/Other billing code:**
Primary Diagnosis:	**ICD-10:**
Drug Requested:	
Strength & Route of Administration:	

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Please note: *This medication requires a* ***prior authorization*** *before Site of Care can be considered. Before submitting a request for Site of Care, please ensure that a prior approval authorization has been submitted and/or approved (pages 1-2 or pages 3-4). Otherwise, this request will deny.*

1. Is the injection/infusion being administered in an **inpatient setting**?.....☐ Yes ☐ No
   a. **If YES,** is the sole purpose of the inpatient admission for giving the injection/infusion?.....☐ Yes ☐ No
2. Is the injection/infusion being administered in an **outpatient hospital setting**?.....☐ Yes ☐ No

   If YES, please answer the following questions:
   a. Does the patient have a history of mild adverse events that have not been successfully managed through mild pre-medication (e.g., diphenhydramine, acetaminophen, steroids, fluids, etc.)?.....☐ Yes ☐ No
   b. Is the patient unable to physically and cognitively adhere to the treatment schedule and regimen complexity?.....☐ Yes ☐ No
   c. Is the patient new to therapy (defined as initial injection/infusion OR less than 3 months since the initial injection/infusion)?.....☐ Yes ☐ No
   d. Is this the first injection/infusion after 6 months of no injections/infusions for medications with approved dosing intervals of less than 6 months?.....☐ Yes ☐ No
   e. Is this the first injection/infusion after at least a 1-month gap in therapy outside of the approved dosing interval for medications requiring every 6 months dosing duration?.....☐ Yes ☐ No
   f. Is this request required due to a change in formulation of the requested medication?.....☐ Yes ☐ No

****NOTE: continued on page 6, please sign page 6 for Site of Care request****

BlueCross BlueShield of North Carolina

eptinezumab-jjmr (Vyepti™) – SITE OF CARE

INTRAVENOUS INFUSION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-888-348-7332