BlueCross BlueShield

BlueShield. VYEPTI Federal Employee Program. PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn. Clinical Services Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the

| physician portion and sub | omit this completed form. | | | · · · | 01 9 | Fax: | 1-8//-3/8-4/2/ | |
|--------------------------------|---------------------------|--------------------|------|--|----------------------|-------------|----------------|--|
| Patient Information (required) | | | | Provider Information (required) | | | | |
| Date: | | | | Provider Name: | | | | |
| Patient Name: | | | | Specialty: | NF | NPI: | | |
| Date of Birth: | | Sex: DMale DFemale | | Office Phone: | Of | Office Fax: | | |
| Street Address: | | | | Office Street Address: | | | | |
| City: | | State: | Zip: | City: | State: | | Zip: | |
| Patient ID: R | | | | | Physician Signature: | | | |
| PHYSICIAN COMPLETES | | | | | | | | |

Vyepti

(eptinezumab-jjmr)

**Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

NOTE: Form must be completed in its entirety for processing

Is this request for brand or generic? Brand Generic

How many vials will the patient need for a 90 day supply? ______ vial(s) per 90 days

- 1. What is the patient's diagnosis?
 - □ Migraine
 - □ Other diagnosis (*please specify*): _____
- 2. Is Vypeti being used for the prevention of migraines? □Yes □No
- 3. Is the patient currently using another calcitonin-gene-related peptide (CGRP) antagonist medication such as Aimovig, Ajovy, Emgality, Nurtec ODT, Qulipta, or Ubrely? □Yes* □No, not using another CGRP

*If YES, is this a change or a request for an additional therapy? Please select answer below:

Change from another CGRP (*please specify*): _

Request for additional therapy (*please specify*): ____

4. Has the patient been on Vyepti continuously for the last 4 months, excluding samples? Please select the answer below:

- **NO** this is **INITIATION** of therapy, please answer the following questions:
 - a. Has the patient completed an adequate six month trial of at least **TWO** of the following prophylactic agents: divalproex sodium (Depakote, Depakote ER), topiramate (Topamax), amitriptyline (Elavil), venlafaxine (Effexor), or a beta-blocker which includes atenolol, metoprolol, nadolol, propranolol, or timolol? **Tyes D**No
 - b. Does the patient have an intolerance or contraindication to at least **ONE** of the following triptan agents: Amerge (naratriptan), Axert (almotriptan), Frova (frovatriptan), Imitrex (sumatriptan), Maxalt (rizatriptan), Relpax (eletriptan), or Zomig (zolmitriptan)? **D**Yes **D**No*

*If NO, has the patient completed an adequate three month trial of at least ONE of the triptan agents? \Box Yes \Box No

- **YES** this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
 - a. Has the patient had a documented decrease in migraine days from baseline **OR** an improvement in daily activities due to the reduction of debilitating migraines? \Box Yes \Box No



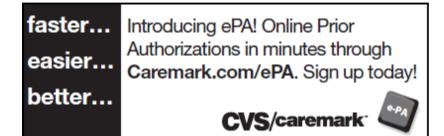
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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

| Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST | Now you can get responses to drug Prior Authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA. |
|---|--|
| Phone (4-5 minutes for response) | The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM- 9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes. |
| Fax (3-5 days for response) | Fax the attached form to (877)-378-4727. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <u>Please only fax the completed form once as</u> <u>duplicate submissions may delay processing</u> <u>times.</u> |



The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and l agree to provide any such information to the insurer. Vyepti – FEP MD Fax Form Revised 5/20/2022