Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Vyepti
(eptinezumab-jjmr)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations, we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed. *		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ICD10:

☐ Vyepti 100mg/ml vial ☐ other (please specify):

Directions for use: Dosing and Quantity: Duration of therapy:

Frequency of therapy:

Where will this medication be obtained?
☐ Orsini Specialty Pharmacy
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is your patient's diagnosis?
☐ Acute Treatment of Migraine
☐ Cluster Headache, Treatment or Prevention
☐ Migraine Headache Prevention
☐ All other indications or diagnoses

Clinical Information

Is the requested medication to be used in combination with another calcitonin gene-related peptide (CGRP) inhibitor being prescribed for migraine headache prevention? CGRP inhibitors that are indicated for migraine headache prevention include Aimovig (erenumab-aooe subcutaneous injection), Ajovy (fremanezumab-vfrm subcutaneous injection), Emgality (galcanezumab-gnlm subcutaneous injection), and Qulipta (atogepant tablets). ☐ Yes ☐ No

Is the requested medication to be used in combination with Nurtec ODT (rimegepant sulfate orally disintegrating tablet) when used as a preventive treatment of migraine? ☐ Yes ☐ No

Does/Did the patient have greater than or equal to 4 (four) migraine headache days per month (prior to initiating a migraine-preventative medication)? ☐ Yes ☐ No

Is the patient currently taking Vyepti? ☐ Yes ☐ No

(if yes) Has the patient had a significant clinical benefit from the medication as determined by the prescriber? Note: Examples of significant clinical benefit include a reduction in the overall number of migraine days per month or a reduction in number of severe migraine days per month from the time that Vyepti was initiated. ☐ Yes ☐ No

(if currently taking) Has the patient been receiving samples or coupons or other types of waivers in order to obtain Vyepti? ☐ Yes ☐ No

Which of the following has the patient tried? Check all that apply.
☐ Aimovig (erenumab-aooe) [requires prior authorization]
☐ Ajovy (fremanezumab-vfrm) [requires prior authorization]
☐ Emgality (galcanezumab-gnlm) [requires prior authorization]
☐ Qulipta (atogepant) [requires prior authorization]

For those drugs checked above, has the patient had inadequate efficacy or significant intolerance to them, according to the prescriber? ☐ Yes ☐ No

Additional Pertinent Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v050126