Blue Cross Blue Shield Blue Care Network of Michigan

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# Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠
# Medication Authorization Request Form
# Vyepti™ (eptinezumab-jjmr) J3590

**The most efficient way to request authorization is to use the NovoLogix® system. To access NovoLogix, visit bcbsm.com/providers and log in to Provider Secured Services. Click the link for Medical Prior Authorization. As an alternative, you can use this form to request authorization. Complete this form and fax to 1-866-392-6465. If you have any questions regarding this process, contact the Pharmacy Clinical Help Desk at 1-800-437-3803.**

| PATIENT INFORMATION | PHYSICIAN INFORMATION |
|---|---|
| **Name** | **Name** |
| **ID Number** | **Specialty** |
| **Date of birth** ☐Male ☐Female | **Address** |
| **Diagnosis (include ICD-10)** | **City /State/Zip** |
| **Drug Name** | **Phone:** ( ) - **Fax:** ( ) - |
| **Dose and Quantity** | **NPI** |
| **Directions** | **Contact Person** |
| **Date of Services** | **Contact Person's Phone / Ext.** |

**STEP 1: DISEASE STATE INFORMATION**

1. Is this request for initiation or continuation of Vyepti™? ☐ Initiation ☐ Continuation Date of last injection _____
2. For what diagnosis is Vyepti™ being prescribed? ☐ Preventive treatment of migraines ☐ Other_____
3. How many days per month does the patient have migraine headaches (lasting 4 hours a day or longer)? _____ days
4. Which of the following therapies has the patient tried and failed for at least a 2-month period? Select all that apply.
   ☐ Anticonvulsants (examples: Depakote®, Topamax®) ☐ Beta Blockers (examples: Propranolol, metoprolol)
   ☐ Calcium Channel Blockers (examples: Verapamil, Diltiazem) ☐Antidepressants (examples: Amitriptyline, venlafaxine)
   ☐ ACE inhibitors or Angiotensin Receptor Blockers (examples: lisinopril, candesartan)
5. Which of the following therapies has the patient tried and failed? Select all that apply.
   ☐ Aimovig® ☐ Ajovy® ☐ Emgality®
   ☐ Botox ® ☐ Other_____
6. Will Vyepti™ be used in combination with another CGRP antagonist or Botox®? ☐ Yes ☐ No
7. **For continuation only**: Did the member achieve at least 50% or greater reduction in monthly migraine days from baseline?
   ☐ Yes ☐ No

Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

**Coverage won't be provided if the prescribing physician's signature and date aren't reflected on this document.**

☐ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

**Physician's Name** **Physician's Signature** **Date**

| | | |
|---|---|---|
| **Step 2:** Checklist | ☐ Form Completely Filled Out<br>☐ Attached Chart Notes | ☐ Concurrent Medical Problems<br>☐ Prior Therapies |
| **Step 3:** Submit | **Fax the completed form to 1-866-392-6465** | |

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