HIGHMARK HEALTH OPTIONS

Updated: 09/2025
Approved: 09/2025

Request for Prior Authorization for Vyepti (eptinezumab)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Vyepti (eptinezumab) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Vyepti (eptinezumab) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of migraine prophylaxis and the following criteria is met:

- The request dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines.
- For non-preferred agents, the member has had a trial and failure of preferred agent(s) or submitted a clinical reason for not having a trial of preferred agent(s).
- Cannot be used concomitantly with another CGRP for the same indication (e,g, 2 CGRPs cannot both be used for prophylaxis).
- Documentation the member has at least 4 headache days per month
- Documentation that the member has tried and failed for at least 2 months (at optimal or maximum tolerated dose) or had an intolerance or contraindication to 2 different preferred prophylactic anti-migraine agents (e.g. divalproex sodium, topiramate, metoprolol, propranolol, etc).
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Documentation the member is having a reduced number of migraine/headache days per month or a decrease in migraine/headache severity.
- **Reauthorization Duration of approval:** 12 months.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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Vyepti (eptinezumab)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

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

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Does member have at least 4 headache days per month? ☐ Yes ☐ No

List below medications member is using or has tried and failed.

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a decrease in severity or frequency of headaches? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date

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This page is only to be used if the form extends to a second page.

DRUG NAME

PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
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MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

MEDICAL HISTORY (Complete for ALL requests)

******Fill in questions as needed******* If you add content to this section that increases the request form to two pages, please have a section on page two that identifies which member the request is being submitted.

☐

☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Add questions as needed

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date