Cigna®

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:

Is this initial therapy or is the patient currently receiving Vyepti?
☐ Initial therapy
☐ Currently receiving Vyepti

(if currently receiving Vyepti) Has the prescriber confirmed that the patient derived a significant clinical benefit from using this medication? 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 no) Please provide support for continued use.

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
☐ Other (please specify):

Clinical Information

Besides the drug being requested, other calcitonin gene-related peptide (CGRP) inhibitors for migraine headache prevention include: Aimovig (erenumab-aooe subcutaneous injection), Ajovy (fremanezumab-vfrm subcutaneous injection), Emgality (galcanezumab-gnlm subcutaneous injection), and Qulipta (atogepant tablets). Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other drug at this time, nor will they in the future. The requested drug is the only drug the patient is/will be using.
☐ The patient is currently on another drug, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another drug, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another drug.
☐ other/unknown

(if other/more than the requested drug) Please provide the rationale for concurrent use.

Besides the drug being requested, other medications for preventive treatment of migraine include Nurtec ODT (rimegepant sulfate orally disintegrating tablet). Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other drug at this time, nor will they in the future. The requested drug is the only drug the patient is/will be using.
☐ The patient is currently on another drug, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another drug, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another drug.
☐ other/unknown

(if other/more than the requested drug) Please provide the rationale for concurrent use.

PRIOR to initiating a migraine-preventative medication, how many days per month is/was your patient experiencing a migraine headache?

☐ 3 or fewer
☐ 4 or more
☐ Unknown

Is there documentation that your patient had failure, contraindication, or intolerance to any of the following? (Check all that apply):

☐ Aimovig (erenumab-aooe)
☐ Ajovy (fremanezumab-vfrm)
☐ Emgality (galcanezumab-gnlm)

For each alternative that your patient didn't try, please provide details why they can't try that alternative [including: contraindications according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has.

Note: preferred drugs vary depending on the patient's health plan.

Additional Pertinent Information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (samples, out of pocket, etc).*

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:**_____

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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.

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