Outpatient Medical Injectable
Vyepti Authorization Request Form
Fax to 833-581-1861
(Medical Benefit Only)

Member Name: _____DOB: _____

Member ID (UMI): _____ ☐ Medicare ☐ Commercial

Address: _____

ORDERING/ATTENDING PROVIDER

Physician Name: _____ NPI: _____

Address: _____

Office Contact: _____ Phone Number: _____Fax Number: _____

SITE OF CARE

Place of Service *(please select one)*

☐ Home Infusion ☐ Office – Professional ☐ Ambulatory Infusion Suite – Professional ☐ Outpatient Hospital

Is the site of care affiliated with a hospital or will the claim be billed as a facility claim? ☐ Yes ☐ No

Place of Service Name: _____ NPI: _____ Tax ID: _____

Address: _____

Drug Supplier *(please select one)*

☐ Supplied by a Specialty Pharmacy *(for Home Infusion, Office – Professional, or Ambulatory Infusion Suite – Professional)*

☐ Buy & Bill *(for Office – Professional or Outpatient Hospital administration)*

Pharmacy Name: _____ Pharmacy NPI: _____

DRUG/DIAGNOSIS INFORMATION

ICD10 Diagnosis Code(s): _____ Diagnosis Code Description: _____

Dose: _____ Frequency: _____ Number of visits requested: _____ Date of Service: _____

CLINICAL INFORMATION
How many days per month does the member experience *headache*?
How many days per month does the member experience *migraine*?
Is this request prescribed by or in consultation with a neurologist or headache specialist? ☐ YES ☐ NO

****Please verify member's eligibility and benefits through the health plan****

Has the member tried and failed adequate trials of prophylactic therapy from at least two different therapy classes (ex: antiseizure, beta blocker, tricyclic antidepressant)? ☐ YES ☐ NO

- Please list all previous prophylactic therapies tried and failed, not tolerated or contraindicated:

_____

_____

If the treatment plan is to use two chemically distinct CGRP inhibitors in combination for preventive and acute use, does the prescriber attest the benefits of therapy outweigh the risks of concurrent use of both medications? ☐ YES ☐ NO

☐ **New Start**	☐ **Continuation of Therapy**
	Date of last infusion: _____ • Has the member had a reduction in the number of migraine days per month by at least 50% from baseline? ☐ YES ☐ NO • The member has had a reduction in migraine days per month by at least_____ days from baseline

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**