



**Outpatient Medical Injectable  
 Vyepi 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

<input type="checkbox"/> <b>New Start</b>	<input type="checkbox"/> <b>Continuation of Therapy</b>  Date of last infusion: _____  <ul style="list-style-type: none"><li>• Has the member had a reduction in the number of migraine days per month by at least 50% from baseline? <input type="checkbox"/> YES <input type="checkbox"/> NO</li><li>• The member has had a reduction in migraine days per month by at least _____ days from baseline</li></ul>
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**Please attach all pertinent clinical information**

Attached:  YES  NO

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