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: ____

Phone Number: _______________________________ Fax Number: ____________________________________

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

VYEPTI (J3032)

ICD10 Diagnosis Code(s): ______________________ Diagnosis Code Description: ____________________________

Dose: _________ Frequency: ________________ Number of visits requested: ______ Date of Service: _________

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

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

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