Clinical Policy: Eptinezumab-jjmr (Vyepti)
Reference Number: CP.PHAR.489
Effective Date: 09.01.20
Last Review Date: 08.20
Line of Business: Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Eptinezumab-jjmr (Vyepti™) a calcitonin gene-related peptide (CGRP) receptor antagonist.

FDA Approved Indication(s)
Vyepti is a calcitonin gene-related peptide antagonist indicated for the preventive treatment of migraine in adults.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Vyepti is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Migraine Prophylaxis (must meet all):
      1. Diagnosis of episodic or chronic migraine;
      2. Member experiences ≥ 4 migraine days per month for at least 3 months;
      3. Prescribed by or in consultation with a neurologist, headache, or pain specialist;
      4. Age ≥ 18 years;
      5. Failure of at least 2 of the following oral migraine preventative therapies, each for 8 weeks and from different therapeutic classes, unless contraindicated or clinically significant adverse effects are experienced: antiepileptic drugs (e.g., divalproex sodium, sodium valproate, topiramate), beta-blockers (e.g., metoprolol, propranolol, timolol), antidepressants (e.g., amitriptyline, venlafaxine);
      6. Failure of Aimovig®, unless contraindicated or clinically significant adverse effects are experienced;
      7. Vyepti is not prescribed concurrently with Botox® or other injectable CGRP inhibitors (e.g., Aimovig, Ajovy®, Emgality®);
      8. Dose does not exceed 100 mg (1 vial) once every 3 months.

   Approval duration: 3 months

B. Other diagnoses/indications
   1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.
II. Continued Therapy

A. Migraine Prophylaxis (must meet all):
   1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   2. Member has experienced and maintained positive response to therapy as evidenced by a reduction in migraine days per month from baseline;
   3. Vyepti is not prescribed concurrently with Botox or other injectable CGRP inhibitors (e.g., Aimovig, Ajovy, Emgality);
   4. If request is for a dose increase, new dose does not exceed one of the following (a or b):
      a. 100 mg (1 vial) once every 3 months;
      b. 300 mg (3 vials) once every 3 months if medical justification for higher dose is provided.

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2):
   1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
      Approval duration: Duration of request or 6 months (whichever is less); or
   2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:
   A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

   Appendix A: Abbreviation/Acronym Key
   CGRP: calcitonin gene-related peptide
   FDA: Food and Drug Administration

   Appendix B: Therapeutic Alternatives
   This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticonvulsants such as: divalproex (Depakote®), topiramate (Topamax®), valproate sodium</td>
<td>Migraine Prophylaxis Refer to prescribing information or Micromedex</td>
<td>Refer to prescribing information or Micromedex</td>
</tr>
<tr>
<td>Beta-blockers such as: propranolol (Inderal®), metoprolol (Lopressor®)*</td>
<td>Migraine Prophylaxis Refer to prescribing information or Micromedex</td>
<td>Refer to prescribing information or Micromedex</td>
</tr>
</tbody>
</table>
V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migraine prophylaxis</td>
<td>The recommended dosage is 100 mg IV every 3 months.</td>
<td>300 mg every 3 months</td>
</tr>
<tr>
<td></td>
<td>Some patients may benefit from a dosage of 300 mg IV every 3 months.</td>
<td></td>
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</tbody>
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VI. Product Availability
Single-dose vial: 100 mg/mL
VII. References

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>HCPSC Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>TBD</td>
<td>Injection, eptinezumab-jjmr, 100 mg</td>
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Reviews, Revisions, and Approvals

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<tr>
<th></th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tr>
<td>Policy created</td>
<td>04.14.20</td>
<td>08.20</td>
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Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering
benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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