Clinical Policy: Eptinezumab-jjmr (Vyepti)

Reference Number: DE.PHAR.489
Effective Date: 01.23
Last Review Date: 01.23
Line of Business: Medicaid

Coding Implications
Revision Log

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 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 an adequate trial of at least THREE preferred* FDA-approved drugs for the indication and/or drugs that are considered the standard of care within the same drug class on the PDL, when such agents exist, at maximum indicated doses, unless clinically significant adverse effect are experienced, or all are contraindicated;
   **Generic is preferred, if available, and brand is not the preferred agent.*
6. If currently receiving treatment with Botox® for migraine prophylaxis and request is for concurrent use of Botox and Vyepti (i.e., not switching from one agent to another), all of the following (a, b, and c):
   a. Sufficient evidence is provided from at least two high-quality*, published studies in reputable peer-reviewed journals or evidence-based clinical practice guidelines that provide all of the following (i – iv):
      **Case studies or chart reviews are not considered high-quality evidence*
      i. Adequate representation of the member's clinical characteristics, age, and diagnosis;
      ii. Adequate representation of the prescribed drug regimen;
      iii. Clinically meaningful outcomes such as a reduction in monthly migraine or headache days;

iv. Appropriate experimental design and method to address research questions (*see Appendix E for additional information*);

b. Member has experienced and maintained positive response to Botox monotherapy as evidenced by a ≥ 30% reduction in migraine days per month from baseline following at least 2 quarterly injection (6 months) of Botox monotherapy;

c. Despite Botox monotherapy, member continues to experience ≥ 4 migraine days per month and/or severe migraine headaches that result in disability and functional impairment;

7. Vyepti is not prescribed concurrently with other injectable or oral CGRP inhibitors (e.g., Aimovig, Ajovy®, Emgality®, Nurtec®, Qulipta™, Ubrelvy™);
8. Dose does not exceed 100 mg (1 vial) once every 3 months.

Approval duration: 6 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 other injectable or oral CGRP inhibitors (e.g., Aimovig, Ajovy, Emgality, Nurtec, Qulipta, Ubrelvy);*
   **This requirement does not apply to CA if member was previously approved via Centene benefit and is currently stable on therapy with both oral and injectable CGRP inhibitors*
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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Anticonvulsants such as: divalproex (Depakote®), topiramate (Topamax®),valproate sodium	**Migraine Prophylaxis** *Refer to prescribing information or Micromedex*	*Refer to prescribing information or Micromedex*
Beta-blockers such as: propranolol (Inderal®), metoprolol (Lopressor®)*, timolol, atenolol (Tenormin®)*, nadolol (Corgard®)*	**Migraine Prophylaxis** *Refer to prescribing information or Micromedex*	*Refer to prescribing information or Micromedex*
Antidepressants/tricyclic antidepressants* such as: amitriptyline (Elavil®), venlafaxine (Effexor®)	**Migraine Prophylaxis** 70 mg SC once monthly Some patients may benefit from a dosage of 140 mg injected subcutaneously once monthly	*Refer to prescribing information or Micromedex*
Aimovig® (erenumab-aaoe)	**Migraine Prophylaxis** 70 mg SC once monthly Some patients may benefit from a dosage of 140 mg injected subcutaneously once monthly	140 mg/month

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Off-label use*

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): serious hypersensitivity to eptinezumab-jjmr or to any of the excipients
- Boxed warning(s): none reported

Appendix D: General Information
- In the PROMISE-I clinical trial, a migraine was classified by the following characteristics: lasted 4–72 hours; with at least two of the following: unilateral location,

pulsating quality, moderate or severe pain intensity, or aggravation by or causing avoidance of routine physical activity; and had one or more of the following: nausea and/or vomiting and photophobia and phonophobia. A probable migraine was a qualifying headache with two of the three preceding criteria.

Appendix E: Appropriate Experimental Design Methods

- Randomized, prospective controlled trials are generally considered the gold standard; however:
  - In some clinical studies, it may be unnecessary or not feasible to use randomization, double-blind trials, placebos, or crossover.
  - Non-randomized prospective clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
- Case reports and chart reviews are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Migraine prophylaxis	The recommended dosage is 100 mg IV every 3 months. Some patients may benefit from a dosage of 300 mg IV every 3 months.	300 mg every 3 months

VI. Product Availability

Single-dose vial: 100 mg/mL

VII. References

1. Vyepti Prescribing Information. Bothell, WA: Lundbeck Seattle BioPharmaceuticals, Inc.; April 2022. Available at: https://www.vyeptihcp.com/. Accessed July 26, 2022.
2. Silberstein SD, Holland S, Freitag F, et al. American Academy of Neurology: Evidence-based guideline update: Pharmacologic treatment for episodic migraine prevention in adults. Neurology 2012; 78: 1337-45.
3. Simpson DM, Hallett M, Ashman EJ, et al. American Academy of Neurology: Practice guideline update summary: Botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache. Neurology 2016; 86: 1818-26.
4. Ashina M, Saper J, Cady R, et al. Eptinezumab in episodic migraine: A randomized, double-blind, placebo-controlled study (PROMISE-1). Cephalalgia 2020 March; 40(3):241-254.
5. Lipton RB, Goadsby PJ, Smith J, et al. Efficacy and safety of eptinezumab in patients with chronic migraine: Promise-2. Neurology. 2020 March 31; 94(13): e1365-1377.
6. Ailani J, Burch RC, Robbins MS, et al. The American Headache Society Consensus Statement: Update on integrating new migraine treatments into clinical practice. Headache. 2021; 61: 1021-1039.

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.

HCPCS Codes	Description
J3032	Injection, eptinezumab-jjmr, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	09.22	11.22

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.