**[Letter of Medical Necessity/Exception Template]**

[Date] Re:

[Insurance Company Contact] Patient: [Patient’s First and Last Name]

[Insurance Company Name] Subscriber ID #: [Insurance Subscriber ID]

[Insurance Company Address] Subscriber Group #: [Insurance Group ID]

[Insurance Company City, State ZIP] Date of Birth: [Patient’s Date of Birth]

Dear [Insurance Company Contact]:

I am writing this [Letter of Medical Necessity/Letter of Medical Exception] on behalf of my patient, [Patient’s First and Last Name], to support coverage of VYEPTI® (eptinezumab-jjmr) [100 mg/300 mg] for the preventive treatment of migraine in adults [ICD-10 code].

[I have read and acknowledge your policy for the responsible management of drugs in this category] or [I acknowledge that your policy currently excludes VYEPTI for the prevention of migraine in favor of other therapies]. This letter serves to document that VYEPTI is medically necessary for [Patient First and Last Name]. On behalf of the patient, I am requesting [approval/an exception] for use in this case.

Below you will find a description of the patient’s medical history, including prior therapies, and [his/her] current comorbidities and diagnoses.

**Medical History, Diagnosis, and Rationale**

[Patient] is [a/an] [age]-year-old [male/female] diagnosed with [chronic/episodic] migraine disease as evidenced by [# of migraine days per month]. [Patient] has been in my care since [date]. As a result of their migraine disease, my patient [enter brief description of patient migraine history as well as clinical evidence. Examples include:

* Baseline and current number of migraine days per month
* Baseline and current Migraine Disability Assessment (MIDAS) and/or Migraine Physical Function Impact Diary (MPFID) and/or Headache Impact Test (HIT-6) scores
* Comorbidities]

Additionally, [Patient Name] has [tried or attempted] the following previous treatments.

Treatment History

* [Prior Treatment Name], [treatment start and end date], and [reason for discontinuation (e.g., intolerance, lack of efficacy)]
* List all prior treatments in above format.
* List any treatments patient was unable to try due to inability to self-inject, contraindications, etc.
* List the status of current treatments that may continue following initiation or continuation of VYEPTI

[Initiation of 100mg or 300 mg]:

Based on my patient’s treatment history and in accordance with the FDA labeling, it is my medical opinion that this patient would benefit from initiation of VYEPTI [100 mg or 300 mg] dose to reduce monthly migraine days (MMDs) and migraine severity. It is my clinical assessment that a reduction in migraine days and migraine severity will have a positive [effect on other abortive medication use, effect on patient functioning, etc.].

[Dose escalation to 300mg only]:

Even though my patient has shown [response and reduction in migraine days] with VYEPTI 100 mg, it is my clinical assessment that we will successfully further reduce or potentially eliminate [Patient Name’s] migraine headaches, thus restoring a high level of functioning by utilizing VYEPTI 300 mg.

[Continuation of 100 mg/300 mg]:

Currently my patient [confirm patient has tolerated VYEPTI with minimal or no side effects]. [Patient Name] has had a response to VYEPTI therapy as measured by a reduction in [# of migraine days per month and/or Migraine Disability Assessment (MIDAS) and/or Migraine Physical Function Impact Diary (MPFID) and/or Headache Impact Test (HIT-6) scores].

Additionally, [Patient] could be at risk of migraine treatment disruption if unable to [increase the dosage of VYEPTI/initiate VYEPTI/continue VYEPTI] [If applicable, insert potential risks of disruption to therapy: e.g., increased migraine days, additional provider visits, other migraine-related medical care, etc].

Based on the above facts, I am confident you will agree that VYEPTI is indicated and medically necessary for this patient. The plan of treatment is to [start/increase the dosage of/continue] the patient [on/to] VYEPTI [100 mg/300 mg]. Administration of VYEPTI is planned on [DATE] and will be continued approximately every 3 months.

Please contact my office by calling [Practice Phone Number] for any additional information you may require in support of coverage for VYEPTI. I look forward to your timely approval.

## Sincerely,

[Physician’s Signature] [Physician’s Name]

[Provider Identification Number] [Name of Practice]

[Phone Number]

**Enclosures:** (attach as appropriate)

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| --- | --- |
| * Any original Letter of Medical Necessity * Patient clinical/diagnostic notes and relevant lab reports | * Published clinical references supporting your letter |