MEDICATION POLICY:

CGRP Inhibitors

Generic Name: N/A

Therapeutic or Brand Name: Calcitonin Gene-Related Peptide (CGRP) Inhibitors

Applicable Drugs (if Therapeutic Class): Aimovig™ (Erenumab-aooe), Ajovy™ (fremanezumab-vfrm), Emgality™ (galcanezumab-gnlm), Nurtec™ (rimegepant), Ubrelvy™ (ubrogepant), Vypeti™ (eptinezumab-jjmr)

GPI Code: 6770202010, 6770203020, 6770203530, 6740654060, 6770108000, 6770201520

Preferred: Ajovy (fremanezumab-vfrm)

Non-preferred: Aimovig (Erenumab-aooe), Emgality (galcanezumab-gnlm), Nurtec (rimegepant), Ubrelvy (ubrogepant), Vypeti (eptinezumab-jjmr)

Date of Origin: 10/2/2018

Date Last Reviewed / Revised: 7/23/2020

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through V are met)

I. Documented diagnosis of one of the following conditions A or B and must meet criteria listed under applicable diagnosis:

A. Episodic migraine headaches (4-14 migraine days per month) or chronic migraines (15 or more headache days per month with at least 8 migraine days per month) and criteria i – IV. Is met:

i. Documentation of functional impairment due to episodic or chronic migraines (eg, severe pain, missed days at school or work, impaired activities of daily living).

ii. Documentation of treatment failure, intolerance, or contraindication to medications from all 3 of the following drug categories A through C for prevention of episodic or chronic migraine headaches:

1. Anticonvulsants (such as Divalproex Sodium or Topiramate)
2. Beta-blockers (such as Metoprolol or propranolol)
3. Antidepressants (such as Venlafaxine or Amitriptyline)

iii. Documentation that evaluation has been performed demonstrating patient does not suffer from rebound headaches due to medication overuse (medication overuse headache, or MOH).

iv. Prescription is for Ajovy OR there is a clinically significant treatment failure, intolerance or contraindication to Ajovy and the prescription is for Aimovig, Emgality, or Vyepti.

B. Acute migraine with or without aura and criteria I - ii are met:

i. Documented clinically significant treatment failure, adverse event, or contraindication to two generic triptans at maximally tolerated doses with repeated use. The two triptans are required to differ in chemical entity and dosage form (oral, nasal, injection).

ii. Prescription is for Nurtec or Ubrelvy.

II. Minimum age requirement: 18 years old.

III. Refer to plan document for the list of preferred products. If requested agent is not listed as a preferred product, must have a documented failure, intolerance, or contraindication to a preferred product(s).

EXCLUSION CRITERIA

- N/A

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- Ajovy™: One 225mg prefilled syringe per 30 days OR three 225mg prefilled syringes (total 675mg) per 90 days.
- Aimovig™ : One pack of ONE 70mg auto-injector pen OR one pack of TWO 70mg auto-injector pens per 30 days.
- Emgality™: lone-time initial fill of TWO 120mg auto-injector pens or syringes followed by ONE 120mg auto-injector pen or syringe per 30 days thereafter.
- Nurtex™: 8 tablets per 30 days
- Ubrelvy™: 10 tablets per 30 days
- Vypeti™: Up to 300 mg every 90 days

APPROVAL LENGTH

- **Authorization:** 6 months.

- **Re-Authorization:** 1 year, with an updated letter of medical necessity or progress notes showing sustained clinical benefits from the drug treatment, including at least a 50% improvement in functional impairment and headache severity from baseline (as measured by a reduction in the need for acute abortive therapies or care, missed days at work or school, and increase in ability to perform activities of daily living compared to baseline).

APPENDIX

- N/A

REFERENCES

1. https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/761077s000lbl.pdf .
2. https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/761089s000lbl.pdf .
3. http://pi.lilly.com/us/emgality-uspi.pdf .
4. https://americanheadachesociety.org/news/new-guidelines-treatments-can-help-prevent-migraine-2/ .
5. https://www.aan.com/Guidelines/home/GetGuidelineContent/545 .
6. https://americanheadachesociety.org/wp-content/uploads/2016/06/Chronic_Migraine_-_February_2013.pdf .

HISTORICAL TRACKING OF CHANGES MADE TO POLICY

	Notes/Changes
7/23/2020	**1. Changed** I.B.i **From** "Documented clinically significant treatment failure, adverse event, or contraindication to both of the following categories 1. Analgesics (e.g. acetaminophen, NSAIDs) AND 2. Triptans (at maximally tolerated doses with repeated use) **To** "Documented clinically significant treatment failure, adverse event, or contraindication to two generic triptans at maximally tolerated doses with repeated use. Two triptans are required to differ in chemical entity and dosage form (oral, nasal, injection)."
4/20/2020	**2. Added "**Nurtec™ (rimegepant), Ubrelvy™ (ubrogepant), Vypeti™ (eptinezumab-jjmr) **under Applicable Drugs (if therapeutic class.** **3. Added** Nurtec™ (rimegepant), Ubrelvy™ (ubrogepant), Vypeti™ (eptinezumab-jjmr) **under "non-preferred".** **4. Added** 6740654060, 6770108000, 6770201520 **under GPI code** **5. Added** I.A.IV. Prescription is for Ajovy OR there is a clinically significant treatment failure, intolerance or contraindication to Ajovy and the prescription is for Aimovig, Emgality, or Vyepti **under Prior Authorization Criteria** **6. Added** I.B. Acute migraine with or without aura and criteria I – ii are met: i. documented clinically significant treatment failure, adverse event, or

	contraindication to both of the following categories: 1. Analgesics. (e.g. acetaminophen, NSAIDs) AND 2. Triptans (at maximally tolerated doses with repeated use) **under Prior Authorization Criteria** **7. Added** II. Minimum age requirement: 18 yeqrs old **under Prior Authorization Criteria** **8. Added** Nurtec™: 8 tablets per 30 days, Ubrelvy ™: 10 tablets per 30 days, Vypeti™ 300 mg every 90 days under **Quantity/Days Supply Restriction**.
6/20/2019	1. **Added** wording in "Quantity/Days Supply Restrictions" section to account for new prefilled syringe dose form. 2. **Added** examples of each drug category **under Prior Authorization Criteria**, **FROM:** III. Documentation that patient has tried and failed or cannot tolerate ALL of the medication options A through C below for prevention of episodic or chronic migraine headaches: A. Divalproex Sodium or Topiramate B. Metoprolol or propranolol C. Venlafaxine or Amitriptyline **TO:** III. Documentation of treatment failure, intolerance, or contraindication to medications from all 3 of the following drug categories A through C for prevention of episodic or chronic migraine headaches: A. Anticonvulsants (such as Divalproex Sodium or Topiramate) B. Beta-blockers (such as Metoprolol or propranolol) C. Antidepressants (such as Venlafaxine or Amitriptyline) 3. **Added** Ajovy™ **under "Preferred"** and Aimovig™ and Emgality™ **under "Non-Preferred"** sections per 5/2019 Ventegra CAC formulary approval. **Added** standard approval criteria for non-preferred agents as item V **under Prior Authorization Criteria.**
10/2/2018	New policy created.