# Clinical Policy: Migraine Acute Treatment Agents

Reference Number: PHW.PDL.021
Effective Date: 01/05/2021
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Revision Log

**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 PA Health and Wellness® that Migraine Acute Treatment Agents are **medically necessary** when the following criteria are met:

## I. Requirements for Prior Authorization of Migraine Acute Treatment Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Migraine Acute Treatment Agents that meet any of the following conditions must be prior authorized:

1. A prescription for a small molecule calcitonin gene-related peptide (CGRP) receptor antagonist (gepant).

2. A prescription for a serotonin (5-HT) 1F receptor agonist (ditan).

3. A prescription for an ergot alkaloid.

4. A non-preferred Migraine Acute Treatment Agent. See the Preferred Drug List (PDL) for the list of preferred Migraine Acute Treatment Agents at: https://papdl.com/preferred-drug-list.

5. A Migraine Acute Treatment Agent with a prescribed quantity that exceeds the quantity limit.

6. A Migraine Acute Treatment Agent when there is a record of a recent paid claim for another Migraine Acute Treatment Agent (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Migraine Acute Treatment Agent, the determination of whether the requested prescription is medically necessary will take into account the whether the member:

1. For a gepant for the preventive treatment of migraine, see PHW.PDL.537 Migraine Prevention Agents; **OR**

2. **Both** of the following:

a. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication
b. Has a diagnosis confirmed according to the current International Headache Society Classification of Headache Disorders;

**AND**

3. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

5. Does not have a contraindication to the prescribed medication; **AND**

6. For a gepant for the acute treatment of migraine, **both** of the following:

   a. **One** of the following:

      i. Has a history of therapeutic failure of at least two (5-HT $_{1B/1D}$) receptor agonists (triptans)
      ii. Has a contraindication or intolerance to the preferred triptans,

   b. If currently using a different gepant, **one** of the following:

      i. Will discontinue use of that gepant prior to starting the requested gepant
      ii. Has a medical reason for concomitant use of both gepants that is supported by peer-reviewed literature or national treatment guidelines;

   **AND**

7. For a ditan, has a history of trial and failure, contraindication, or intolerance to the preferred triptans; **AND**

8. For ergot alkaloids, has a history of trial and failure, contraindication, or intolerance to standard first-line abortive medications based on headache classification as recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society); **AND**

9. For a non-preferred Migraine Acute Treatment Agent, **one** of the following:

   a. For a non-preferred triptan, has a history of therapeutic failure, contraindication, or intolerance to the preferred triptans

b. For all other non-preferred Migraine Acute Treatment Agents (e.g., gepants, ditans, ergot alkaloids, etc.), has a history of therapeutic failure, contraindication, or intolerance to the preferred Migraine Acute Treatment Agents approved or medically accepted for the member's diagnosis or indication;

**AND**

10. For therapeutic duplication, **one** of the following:

    a. Is being titrated to or tapered from another drug in the same class
    b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

    **AND**

11. If a prescription for a Migraine Acute Treatment Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account **all** of the following:

    a. The guidelines set forth in PA.CP.PMN.59 Quantity Limit Override,

    b. Whether the member is prescribed the requested medication by **one** of the following:

        i. A neurologist
        ii. A headache specialist who is certified in headache medicine by the UCNS,

    c. For the acute treatment of migraine, **both** of the following:

        i. **One** of the following:

            a) The member is using the requested medication in addition to at least one medication for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody)
            b) The member has a history of therapeutic failure, contraindication, or intolerance to all preventive migraine medications recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society)

        ii. Has documentation of an evaluation for the overuse of abortive medications, including opioids.

    NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically

necessary to meet the medical needs of the member, the request for prior authorization will be approved.

**FOR RENEWALS OF PRIOR AUTHORIZATION FOR A MIGRAINE ACUTE TREAMENT AGENT**: The determination of medical necessity of a request for renewal of a prior authorization for a Migraine Acute Treatment Agent that was previously approved will take into account whether the member:

1. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

2. Does not have a history of contraindication to the prescribed medication; **AND**

3. Has documentation of improvement in headache pain, symptoms, or duration; **AND**

4. If a prescription for a Migraine Acute Treatment Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account **all** of the following:

    a. The guidelines set forth in PA.CP.PMN.59 Quantity Limit Override,

    b. Whether the member is prescribed the requested medication by **one** of the following:

        i. A neurologist
        ii. A headache specialist who is certified in headache medicine by the UCNS,

    c. For the acute treatment of migraine, **both** of the following:

        i. **One** of the following:

            a) The member is using the requested medication in addition to at least one medication for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody)
            b) The member has a history of therapeutic failure, contraindication, or intolerance to all preventive migraine medications recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society)

        ii. Has documentation of an evaluation for the overuse of abortive medications, including opioids.

    NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically

necessary to meet the medical needs of the member, the request for prior authorization will be approved.

B. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Migraine Acute Treatment Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member.

C. References

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| Reviews, Revisions, and Approvals | Date |
|---|---|
| Q1 2021: policy created according to DHS effective 01/05/2021 | 11/2020 |
| Q1 2022: revised according to DHS revisions effective 01/03/2022 | 10/2021 |
| Q1 2023 annual review: no changes. | 11/2022 |
| Q1 2024 annual review: no changes. | 11/2023 |