Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: N/A**
Policy Number: PHW.PDL.021	**Effective Date: 01/01/2020** **Revision Date: 07/2020**
Policy Name: Antimigraine Agents, Triptans	

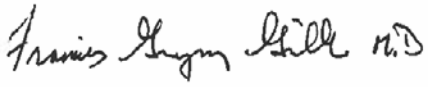
Type of Submission – Check all that apply:

- ☐ **New Policy**
- ☐ **Revised Policy***
- ✓ **Annual Review - No Revisions**
- ✓ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Q3 2020 annual review: no changes.

Name of Authorized Individual (Please type or print): **Francis G. Grillo, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Antimigraine Agents, Triptans

Reference Number: PHW.PDL.021
Effective Date: 01/01/2020
Last Review Date: 07/2020

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 health plans affiliated with PA Health and Wellness® that Triptan Antimigraine Agents are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antimigraine Agents, Triptans

A. Prescriptions That Require Prior Authorization

Prescriptions for Antimigraine Agents, Triptans that meet any of the following conditions must be prior authorized:

1. A non-preferred Antimigraine Agent, Triptan.

2. An Antimigraine Agent, Triptan with a prescribed quantity that exceeds the quantity limit.

3. An Antimigraine Agent, Triptan when there is a record of a recent paid claim for another Antimigraine Agent, Triptan (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antimigraine Agent, Triptan, the determination of whether the requested prescription is medically necessary will take into account the whether the beneficiary:

1. For a non-preferred Antimigraine Agent, Triptan, has a history of therapeutic failure, contraindication, or intolerance to the preferred Antimigraine Agents, Triptans; **AND**

2. 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

3. If a prescription for an Antimigraine Agent, Triptan is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account **both** of the following:

    a. Has a history of chronic, severe migraine as defined by the International Classification of Headache Disorders (ICHD) criteria
    b. Is using the requested medication in addition to a medication for migraine prophylaxis.

NOTE: If the beneficiary 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 beneficiary, the request for prior authorization will be approved.

C. 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 an Antimigraine Agent, Triptan. 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 beneficiary.

D. **Approval Duration: 12 months**

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020