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.537	**Effective Date: 01/01/2020** **Revision Date: 07/2020**
Policy Name: Antimigraine Agents, Other	

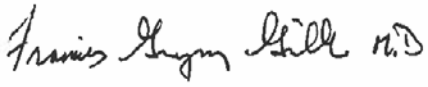
Type of Submission – Check all that apply:

- ☐ **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, Other

Reference Number: PHW.PDL.537
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 Other Antimigraine Agents are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antimigraine Agents, Other

A. Prescriptions That Require Prior Authorization

All prescriptions for Antimigraine Agents, Other must be prior authorized.

B. Review of Documentation for Medical Necessity

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

1. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package insert OR a medically accepted indication; **AND**

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

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

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

5. For a calcitonin gene-related peptide (CGRP) antagonist/inhibitor prescribed for the prevention of migraine, **all** of the following:

    a. Is prescribed the CGRP antagonist/inhibitor by or in consultation with **one** of the following:

        i. A neurologist
        ii. A headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS),

b. Has documentation of baseline average number of migraine days and headache days per month,

c. Has averaged four or more migraine days per month over the previous three months,

d. Has a diagnosis of migraine with or without aura confirmed according to the current International Headache Society Classification of Headache Disorders

e. **One** of the following:

i. Has a history of therapeutic failure of at least one preventive medication from **two** of the following three classes:

a) Beta-blockers (e.g., metoprolol, propranolol, timolol),
b) Antidepressants (e.g., amitriptyline, venlafaxine),
c) Anticonvulsants (e.g., topiramate, valproic acid, divalproex),

ii. Has a history of contraindication or intolerance to all preventive medications from **all** of the following three classes:

a) Beta-blockers (e.g., metoprolol, propranolol, timolol),
b) Antidepressants (e.g., amitriptyline, venlafaxine),
c) Anticonvulsants (e.g., topiramate, valproic acid, divalproex),

f. Will not be using the requested CGRP antagonist/inhibitor with another CGRP antagonist/inhibitor;

AND

6. For a CGRP antagonist/inhibitor prescribed for a diagnosis of episodic cluster headache, all of the following:

a. Is prescribed the CGRP antagonist/inhibitor by or in consultation with **one** of the following:

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

b. Has a diagnosis of episodic cluster headache confirmed according to the current International Headache Society Classification of Headache Disorders,

c. Has a history of therapeutic failure, contraindication, or intolerance of at least

one other preventive medication recommended by current consensus guidelines for episodic cluster headache (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society),

d. Will not be using the requested CGRP antagonist/inhibitor with another CGRP antagonist/inhibitor;

AND

7. For a non-preferred CGRP antagonist/inhibitor, has a history of therapeutic failure, contraindication, or intolerance to the preferred CGRP antagonists/inhibitors approved or medically accepted for the beneficiary's diagnosis.

8. For ergot alkaloids, **both** of the following:

   a. Has a diagnosis of headache based on the current International Headache Society Classification of Headache Disorders
   b. 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. If a prescription for an Antimigraine Agent, Other is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement 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.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR AN ANTIMIGRAINE AGENT, OTHER:
The determination of medical necessity of a request for renewal of a prior authorization for an Antimigraine Agent, Other that was previously approved will take into account whether the beneficiary:

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

2. For a CGRP antagonists/inhibitor prescribed for the prevention of migraine, **all** of the following:

a. **One** of the following:

   i. Has a reduction in the average number of migraine days or headache days per month from baseline
   ii. Has experienced a decrease in severity or duration of migraines from baseline,

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

c. Is prescribed the CGRP antagonist/inhibitor by or in consultation with **one** of the following:

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

AND

3. For a CGRP antagonist/inhibitor prescribed for a diagnosis of episodic cluster headache, **all** of the following:

   a. Has documentation of a positive clinical response to the requested medication as evidenced by a reduction in cluster headache frequency from baseline,

   b. Is prescribed a dose and duration of therapy that is consistent with FDA- approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

   c. Is prescribed the CGRP antagonist/inhibitor by or in consultation with **one** of the following:

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

   AND

4. For ergot alkaloids, **all** of the following:

   a. Has experienced an improvement in headache pain control or duration
   b. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature;

AND

5. If a prescription for an Antimigraine Agent, Other is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit

Override.

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement 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, Other. 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. Dose and Duration of Therapy

Requests for prior authorization of Antimigraine Agents, Other will be approved as follows:

1. Initial requests for prior authorization of CGRP antagonists/inhibitors prescribed for the prevention of migraine will be approved for 6 months.

2. Renewals of requests for prior authorization of CGRP antagonists/inhibitors prescribed for the prevention of migraine will be approved for 12 months.

3. Initial requests for prior authorization of CGRP antagonists/inhibitors prescribed for a diagnosis of episodic cluster headache will be approved for 4 months.

4. Renewals of requests for prior authorization of CGRP antagonists/inhibitors prescribed for a diagnosis of episodic cluster headache will be approved for 6 months.

E. References

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19. Mayans L, Walling A. Acute migraine headache: treatment strategies. American Family Physician. 2018;97(4):243-251.
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Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020