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: 11/2020**
Policy Number: PHW.PDL.###	**Effective Date: 01/05/2021** **Revision Date: 11/2020**
Policy Name: Migraine Acute Treatment Agents	

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:

Q1 2021: policy created according to DHS effective 01/05/2021

Name of Authorized Individual (Please type or print): **Auren Weinberg, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Migraine Acute Treatment Agents

Reference Number: PHW.PDL.###
Effective Date: 01/05/2021
Last Review Date: 11/2020

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 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 beneficiary:

1. **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

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 gepant, **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 history of contraindication or intolerance to the preferred triptans,

   b. Will not be using the requested gepant with another gepant or a CGRP monoclonal antibody;

   AND

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

7. 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**

8. 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, has a history of therapeutic failure, contraindication, or intolerance to the preferred Migraine Acute Treatment Agents approved or medically accepted for the beneficiary's diagnosis;

   AND

9. 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

10. 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 beneficiary 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 beneficiary 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 beneficiary 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 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.

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 beneficiary:

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. For a gepant, will not be using the requested gepant with another gepant or CGRP monoclonal antibody; **AND**

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

5. 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 beneficiary 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 beneficiary 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 beneficiary 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 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.

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 beneficiary.

C. References

1. American Headache Society. The American Headache Society position statement on integrating the new migraine treatments into clinical practice. Headache. 2019;59:1-18.
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4. Frova Package Insert. Malvern, PA: Endo Pharmaceuticals Inc.; August 2018.
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6. Institute for Clinical Systems Improvement. Diagnosis and treatment of headache. eleventh edition. January 2013.
7. International Headache Society. Headache Classification Committee of the International Headache Society (IHS): the international classification of headache disorders, 3rd edition. Cephalalgia. 2018; Vol. 38(1):1-211.
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11. Nurtec ODT Package Insert. New Haven, CT: Biohaven Pharmaceuticals, Inc.; February 2020.
12. Relpax Package Insert. New York, NY: Roerig Division of Pfizer Inc.; March 2020.
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15. Treximet Package Insert. Morristown, NJ: Pernix Therapeutics, LLC; July 2019.
16. Ubrelvy Package Insert. Madison, NJ: Allergan USA, Inc.; December 2019.
17. Zembrace SymTouch Package Insert. Princeton, NJ: Promius Pharma; June 2019.
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Reviews, Revisions, and Approvals	Date
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