Clinical Policy: Migraine Acute Treatment Agents

Reference Number: PHW.PDL.021
Effective Date: 01/05/2021
Last Review Date: 11/2025

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 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.

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

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

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

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

6. A prescription for an ergot alkaloid.

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 drug; **AND**

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

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

AND

7. For a ditan, has a history of therapeutic failure of or a contraindication or anintolerance to the preferred triptans; **AND**

8. For ergot alkaloids, has a history of therapeutic failure of or a contraindication or an intolerance to standard first-line abortive drugs 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 of or a contraindication or an intolerance to the preferred triptans,
b. For a non-preferred gepant, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred gepants,
c. For a non-preferred non-steroidal anti-inflammatory drug (NSAID) (e.g., Elyxyb [celecoxib] solution, diclofenac potassium powder packet), has a history of therapeutic failure of or a contraindication or an intolerance to the preferred oral NSAIDs (excluding ketorolac) approved or medically accepted for the member's diagnosis in the NSAIDs Statewide PDL class,

d. For a non-preferred triptan-NSAID combination product, **all** of the following:
   i. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred triptans,
   ii. Has a clinical reason as documented by the prescriber why the individual active ingredients cannot be used concurrently,
   iii. In addition, for Symbravo (meloxicam-rizatriptan), has a history of therapeutic failure of or a contraindication or an intolerance to sumatriptan-naproxen tablet,

e. For non-preferred Migraine Acute Treatment Agents other than triptans, gepants, NSAIDs, and triptan-NSAID combination products (e.g., ditans, ergot alkaloids, etc.), has a history of therapeutic failure of or a contraindication or an 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 drugs that is supported by peer-reviewed medical 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 drug by **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),

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

       i. **One** of the following:

          a) The member is using the requested drug in addition to at least one drug for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody, gepant, botulinum toxin)
          b) The member has a history of therapeutic failure of or a contraindication or an intolerance to all preventive migraine drugs 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 drugs, 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 contraindication to the prescribed drug; **AND**

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

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

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

   c. For a non-preferred NSAID (e.g., Elyxyb [celecoxib] solution, diclofenac potassium powder packet), has a history of therapeutic failure of or a contraindication or an intolerance to the preferred oral NSAIDs (excluding ketorolac) approved or medically accepted for the member's diagnosis in the NSAIDs Statewide PDL class,

   d. For a non-preferred triptan-NSAID combination product, **all** of the following:

      i. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred triptans,
      ii. Has a clinical reason as documented by the prescriber why the individual active ingredients cannot be used concurrently,
      iii. In addition, for Symbravo (meloxicam-rizatriptan), has a history of therapeutic failure of or a contraindication or an intolerance to sumatriptan-naproxen tablet,

e. For non-preferred Migraine Acute Treatment Agents other than triptans, gepants, NSAIDs, and triptan-NSAID combination products (e.g., ditans, ergot alkaloids, etc.), has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents approved or medically accepted for the member's diagnosis or indication; AND

5. 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 drugs that is supported by peer-reviewed medical literature or national treatment guidelines;

AND

6. 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 drug 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 drug in addition to at least one drug for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody, gepant, botulinum toxin)
         b) The member has a history of therapeutic failure of or a contraindicationor an intolerance to all preventive migraine drugs 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 drugs, 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
Q1 2025: policy revised according to DHS revisions effective 01/06/2025.	11/2024
Q1 2026: policy revised according to DHS revisions effective 01/05/2026.	11/2025