



Prior Authorization Criteria

Calcitonin Gene Related Peptides (CGRP) inhibitors PA Criteria

- **AIMOVIG™ (erenumab-aooe)**
- **AJOVY™ (fremanezumab-vfrm)**
- **EMGALITY™ (galcanezumab-gnlm)**

AIMOVIG, AJOVY and EMGALITY impact calcitonin gene-related peptides, which have been observed to increase during a migraine. These drugs are indicated for the *preventive* treatment of migraine.

Emgality 300mg is indicated for the treatment of episodic cluster headache in adults.

Denial Criteria for any of the CGRP inhibitors: Medication will not be used in combination with another (CGRP) inhibitor

- Medication will not be used within 12 weeks of date of last Botox® administration
- No history of myocardial infarction, stroke, unstable angina, and coronary bypass surgery or other revascularization procedures within the past 12 months, vascular ischemia, deep vein thrombosis, pulmonary embolism or thrombotic events
- Currently pregnant or nursing
- Medication Overuse Headache, Hemiplegic Migraine or Tension-Type Headache

CGRP use for Acute or Chronic Migraine

- Must be prescribed by a neurologist or a primary care physician. All other prescribers must consult with a neurologist prior to submission of a prior authorization request.

Required Medical Information:

- Diagnosis of Episodic or Chronic Migraine
- Chart notes (documentation required upon request)
- Previous therapies tried/failed

Initial Authorization-Episodic or Chronic migraine: *Select product requested*

- Aimovig 70mg/1ml subcutaneous once monthly
- Aimovig 140mg/2ml subcutaneously once monthly (*2 consecutive 70 mg-SC injections*)



- Ajovy 225mg/1.5ml subcutaneously once monthly
- Ajovy 675mg/4.5ml subcutaneously once quarterly (*3 consecutive 225mg-SC injections*)
- Emgality 240 mg/1ml subcutaneously ***once as loading dose**** (*2 consecutive 120-mg injections*) ***followed by*** Emgality 120 mg subcutaneously once monthly

* Please document date of first administered dose in prescriber's office of requested medication. _____

A. Episodic Migraine

1. Initial Authorization: 12 weeks

- Patient must be within the age range as recommended by the FDA label
AND
- Documentation of at least 4 to 14 migraine days per month, but no more than 14 headaches per month
AND
- Documented failure to a consecutive 8-week trial as evidenced by paid pharmacy claims, *OR* intolerance *OR* contraindication, of at least ONE therapy, from any TWO of the following different therapeutic classes:
 - (a) Antidepressants: amitriptyline or venlafaxine
 - (b) Antiepileptics: divalproex sodium, sodium valproate, or topiramate
 - (c) Beta-blockers: metoprolol, propranolol, timolol, atenolol, nadolol

B. Chronic Migraine

1. Initial Authorization: 12 weeks

- Patient must be within the age range as recommended by the FDA label
AND
- Documentation of greater than or equal to 15 headache days per month, of which at least 8 must be migraine days for at least 3 months.
AND
- Documented failure to a consecutive 8-week trial as evidenced by paid pharmacy claims for drugs "a-d" below, or a 12-week trial for "e", onabotulinumtoxinA, as documented by physician attestation and/ or paid medical claims *OR* intolerance *OR* contraindication of at least ONE therapy, from any TWO of the following different therapeutic classes:



- (a) Antidepressants: amitriptyline or venlafaxine
- (b) Antiepileptics: divalproex sodium, valproate sodium, or topiramate
- (c) Beta-blockers: metoprolol, propranolol, timolol, atenolol, nadolol,
- (d) Botulinum Toxin serotype A: *specifically* onabotulinumtoxinA (Botox®)

Reauthorization for Episodic or Chronic Migraine: 12 months

Select product requested:

- Aimovig 70mg subcutaneous once monthly
- Aimovig 140mg subcutaneously once monthly (*2 consecutive injections of 70mg*)
- Ajovy 225mg subcutaneously once monthly
- Ajovy 675mg subcutaneously once quarterly (*3 consecutive injections of 225 mg*)
- Emgality 120 mg subcutaneously once monthly

Reauthorization will be based on the following criteria:

- Positive response to therapy demonstrated by a reduction in frequency or severity of migraines [documentation required]; **AND**
- Patient has an overall improvement in function with therapy; **AND**
- Verified pharmacy prescription claims history of Aimovig, Ajovy or Emgality and demonstrated adherence to monthly or quarterly fills per FDA approved dosing.

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C. Episodic Cluster Headache

Select product requested:

- Emgality 300 mg subcutaneously once quarterly (*3 consecutive injections of 100 mg*)

Required Medical Information:

- Diagnosis of Episodic Cluster Headache
- Chart notes (documentation required upon request)
- Previous therapies tried/failed

**Initial Authorization: Episodic Cluster Headache**

Emgality 300 mg* (3 consecutive injections of 100 mg) at the onset of the cluster period, and then monthly until the end of the cluster period

* Please document date of first administered dose in prescriber's office of requested medication. _____

1. Episodic Cluster Headaches -Initial Therapy (Emgality only: 12 weeks)

- Yes No Patient must be within the age range as recommended by the FDA label;
AND
- Yes No Diagnosis of episodic cluster headaches;
AND
- Yes No At least 2 cluster periods lasting from 7 days to \leq 1 year each and separated by pain-free remission periods of \geq 3 months;
AND
- Yes No Prescribed by or in consultation with a neurologist or headache specialist;
AND
- Yes No Failure of verapamil at a dose of 360 mg per day, unless contraindicated or clinically significant adverse effects are experienced;
AND
- Yes No Emgality is not prescribed concurrently with other injectable CGRP antagonists or inhibitors;
AND
- Yes No Dose does not exceed 300 mg once monthly.

2. Episodic Cluster Headaches Reauthorization (Emgality only: up to a total of 12 months supply per cluster period)

- Yes No Positive response to therapy demonstrated by a reduction in cluster headache attack frequency;
AND
- Yes No Must meet one of the following:
- a. Patient has not received more than 12 months of consecutive treatment;
OR
 - b. It has been at least 3 months since the patient last received Emgality;
- AND**
- Yes No Emgality is not prescribed concurrently with other injectable CGRP antagonist antagonists or inhibitors;
AND
- Yes No Dose does not exceed 300 mg once monthly.



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