Prior Authorization Criteria

Injectable 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.

VYEPTI™ (eptinezumab-jjmr) – Please see separate criteria at https://medicaid.ms.gov/manual-prior-authorization -criteria/

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
- 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

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

Preferred Agents

- 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)
Non-preferred Agents (must try and fail 2 preferred agents or provide evidence as to why that is unreasonable)

□ 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

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

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.

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

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

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;  
  \textit{AND}
☐ Yes ☐ No  Must meet one of the following:  
  a. Patient has not received more than 12 months of consecutive treatment;  
  \textit{OR}
  b. It has been at least 3 months since the patient last received Emgality;  
  \textit{AND}
☐ Yes ☐ No  Emgality is not prescribed concurrently with other injectable CGRP antagonist antagonists or inhibitors;  
  \textit{AND}
☐ Yes ☐ No  Dose does not exceed 300 mg once monthly.