

## Pharmacy Policy

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# Calcitonin Gene-Related Peptide Antagonist (CGRP)

**Policy Number:** 9.205

**Version Number:** 2.0

**Version Effective Date:** 6/1/2021

Product Applicability  All Plan+ Products

### Well Sense Health Plan

New Hampshire Medicaid

### Boston Medical Center HealthNet Plan

MassHealth - MCO

MassHealth - ACO

Qualified Health Plans/ConnectorCare/Employer Choice Direct

Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

## Prior Authorization Policy

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### Products Affected:

#### Injectable CGRP Antagonists

- Aimovig (Erenumab-aooe)
- Ajovy (fremanezumab-vfrm)
- Emgality (galcanezumab-gnlm)

#### Oral CGRP Antagonists

- Nurtec (rimegepant)
- Reyvow (lasmiditan)
- Ubrelvy (ubrogepant)

The Plan may authorize coverage of the above products for members meeting the following criteria:

<b>Covered</b>	<u>Aimovig, Ajovy, Emgality</u> : Preventive treatment of migraine in adults. Medically accepted indications
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<b>Use</b>	will also be considered for approval.  <u>Nurtec, Reyvow, Ubrelvy</u> : The treatment of acute migraines
<b>Exclusion Criteria</b>	<u>Aimovig, Ajovy, Emgality</u> : Concomitant use with Botox
<b>Required Medical Information</b>	<p><u>Aimovig, Ajovy, Emgality</u>:</p> <ol style="list-style-type: none"> <li>1. Prescriber attests that patient has a diagnosis of episodic migraines with greater than 4 migraine days per month AND less than 15 headache days per month; <b>OR</b></li> <li>2. Prescriber attests that patient has a diagnosis of chronic migraines with 15 or more headache days per month; <b>AND</b></li> <li>3. Member has tried and failed (trial period of at least 3 months per therapy) at least <b>THREE</b> migraine prophylaxis medications listed below from at least three different therapeutic classes OR has a contraindication to ALL of the following: <ol style="list-style-type: none"> <li>i. Beta blockers: metoprolol, propranolol, timolol, atenolol, nadolol, nebivolol, pindolol</li> <li>ii. Antidepressants: amitriptyline, venlafaxine</li> <li>iii. Anticonvulsants: carbamazepine, divalproex, valproic acid, topiramate</li> <li>iv. Botox (for chronic migraine only); <b>AND</b></li> </ol> </li> <li>4. Product will not be used concomitantly with Botox</li> </ol> <p><u>Nurtec, Reyvow, Ubrelvy</u></p> <ol style="list-style-type: none"> <li>1. A diagnosis of migraine; <b>AND</b></li> <li>2. Medication is being prescribed by or in consultation with a neurologist or headache specialist; <b>AND</b></li> <li>3. Member is 18 years of age or older; <b>AND</b></li> <li>4. Member has tried and failed treatment with at least <b>THREE</b> triptans at maximally indicated doses OR has a contraindication to all triptans; <b>AND</b></li> <li>5. Provider attests that the medication will be used for the acute treatment of migraine, and not for migraine prevention</li> </ol>
<b>Age Restriction</b>	18 years of age and older
<b>Prescriber Restriction</b>	Prescribed by or in consultation with a neurologist, pain specialist, or physician certified in headache medicine.
<b>Coverage Duration</b>	12 months
<b>Other criteria</b>	<p>Reauthorization for Aimovig, Ajovy, Emgality:</p> <ol style="list-style-type: none"> <li>1. Prescriber attests that patient has experienced a positive response to therapy as documented by reduction in headache frequency or improvement of functional ability.</li> </ol>

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	<p>Reauthorization for Nurtec, Reyvow, Ubrelvy:</p> <ol style="list-style-type: none"> <li>1. The member is currently receiving the medication via Boston Medical Center HealthNet Plan benefit or the member previously met initial approval criteria; <i>AND</i></li> <li>2. Prescriber attests that the member has experienced a positive response to therapy</li> </ol>
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**Applicable Coding:**

**Clinical Background Information and References**

1. Aimovig (erenumab-aooe) [prescribing information]. Thousand Oaks, CA: Amgen Inc; May 2018.
2. Silberstein SD, Holland S, Freitag F, Dodick DW, Argoff C, Ashman E. Evidence-based guideline update: pharmacologic treatment for episodic migraine prevention in adults: report of the Quality Standards Subcommittee of the American Academy of Neurology and the American Headache Society. *Neurology*. 2012 Apr 24;78(17):1337-45. Accessed via <http://www.guideline.gov/content.aspx?id=36898>. July 2018.
3. Hayes Medical Technology Directory. Botulinum Toxin Treatment for Migraine Headache. Winifred Hayes, Inc. September 22, 2011. Updated October 15, 2013
4. Ajovy (fremanezumab-vfrm) [prescribing information]. North Wales, PA: Teva Pharmaceuticals USA, Inc. Jan 2020.
5. Emgality (galcanezumab-gnlm) [prescribing information]. Indianapolis, IN: Lilly USA, LLC. Dec 2019.
6. Nurtec (rimegepant sulfate) [prescribing information]. New Haven, CT: Biohaven Pharmaceuticals, Inc. February 2020.
7. Reyvow (lasmiditan) [prescribing information]. Indianapolis, IN: Eli Lilly and Company. January 2021
8. Ubrelvy (ubrogepant) [prescribing information]. Madison, NJ: Allergan, Inc. June 2020.

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	Summary of Revisions	Revision Effective Date	Approved by
12/1/2020	9.085 CGRP Policy retired, new policy created	1/1/2021	P&T Committee

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## Policy Revisions History

2/11/2021	P&T annual review. Added Nurtec, Reyvow, and Ubrelvy policy; updated trial/failure criteria for injectable CGRP antagonists.	6/1/2021	P&T Committee
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## Next Review Date

2/2022

## Other Applicable Policies

## Reference to Applicable Laws and Regulations, If Any

### Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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