Updated: 11/2023
DMMA Approved: 11/2023

Request for Prior Authorization for
Calcitonin gene-related peptide (CGRP) Inhibitors and Serotonin (5-HT)1F receptor agonists
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for CGRP Inhibitors and Serotonin (5-HT)1F Receptor Agonists require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Calcitonin gene-related peptide (CGRP) inhibitors products include Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab), Ubrelvy (ubrogepant), Qulipta (atogepant), Zavzpret (zavegepant), and Nurtec ODT (rimegepant). Serotonin (5-HT)1F Receptor Agonists include Reyvow (lasmiditan). New products with this classification will require the same documentation.

Prior Authorization Criteria:

For all requests for calcitonin gene-related peptide inhibitors and serotonin (5-HT)1F receptor agonists all of the following criteria must be met:

- Is age appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- For non-preferred agents, the member has had a trial and failure of preferred agent(s) or submitted a clinical reason for not having a trial of preferred agent(s).
- Medications with the same mechanism of action cannot be used concomitantly for the same indication (e.g. 2 CGRPs cannot both be used for prophylaxis)
- Any request for a medication that can be used for prophylactic or acute treatment must specify how the medication will be used.

Coverage may be provided with a diagnosis of episodic migraine prophylaxis and the following criteria is met:

- Documentation the member has 4 to 14 headache days per month
- Documentation that the member has tried and failed for at least 2 months (at optimal or maximum tolerated dose) or had an intolerance or contraindication to two different prophylactic agents (i.e. divalproex sodium, sodium valproate, topiramate, metoprolol, and propranolol)
- **Initial Duration of Approval**: 3 months
- **Reauthorization criteria**
    - Documentation the member is having a reduced number of migraine/headache days per month or a decrease in migraine/headache severity

- **Reauthorization Duration of approval**: 12 months

Coverage may be provided with a diagnosis of chronic migraine prophylaxis and the following criteria is met:

- Documentation the member has at least 15 headache days per month for 3 or more months with at least 8 migraine days per month
- Documentation that the member has tried and failed for at least 2 months (at optimal or maximum tolerated dose) or had an intolerance or contraindication to two different prophylactic agents (i.e. divalproex sodium, sodium valproate, topiramate, metoprolol, and propranolol)
- **Initial Duration of Approval**: 3 months
- **Reauthorization criteria**
  - Documentation the member is having a reduced number of migraine/headache days per month or a decrease in migraine/headache severity
- **Reauthorization Duration of approval**: 12 months

Coverage may be provided with a diagnosis of episodic cluster headache and the following criteria is met (Emgality only):

- Documentation the member has at least one cluster attack every other day and no more than 8 attacks a day
- Documentation that the member has tried and failed or had an intolerance or contraindication to both of the following:
  - Verapamil for at least 2 weeks
  - Suboccipital steroid injection
- **Initial Duration of Approval**: 3 months
- **Reauthorization criteria**
  - Documentation the member is having a reduced number of migraine/headache days per month or a decrease in migraine/headache severity
- **Reauthorization Duration of approval**: 12 months

Coverage may be provided with a diagnosis of acute migraine and the following criteria is met:

- Documentation that the member has tried and failed two (2) triptans unless the member has one of the following contraindications:
  - Ischemic coronary artery disease including angina pectoris, history of myocardial infarction, documented silent ischemia, coronary artery vasospasm
  - History of stroke or TIA
  - Peripheral vascular disease
  - Ischemic bowel disease
  - Uncontrolled hypertension
- For Reyvow (lasmiditan), the member has been counseled on avoidance of driving or operating machinery until at least 8 hours after each dose.

- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
  - Documentation of clinical benefit during an acute migraine attack.
- **Reauthorization Duration of approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

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CGRP INHIBITORS AND SEROTONIN (5-HT)1f RECEPTOR AGONISTS PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

What is this being used for? ☐ Treatment ☐ Prophylaxis

For Prophylaxis of episodic migraine, how many headache days does the member have per month? ☐ 1 – 3 ☐ 4 – 14 ☐ ≥ 15

For Prophylaxis of chronic migraine,

- How many headache days does the member have per month? ☐ 1 – 3 ☐ 4 – 14 ☐ ≥ 15
- Has the member been experiencing migraines for at least 3 months with at least 8 migraines per month? ☐ Yes ☐ No

For Treatment of Episodic Cluster Headache, how many attacks does the member have?
☐ Less than every other day ☐ Every other day ☐ 1-8 per day ☐ > 8 per day

For Reyvow, has the member been counseled on avoidance of driving or operating machinery after each dose? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

For prophylaxis of episodic & chronic migraine and treatment of episodic cluster headache, has the member experience a decrease in severity or frequency? ☐ Yes ☐ No

For treatment of migraine, has the member experienced benefit during a migraine? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date