Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

ANTIMIGRAINE AGENTS, OTHER

I. Requirements for Prior Authorization of Antimigraine Agents, Other

A. Prescriptions That Require Prior Authorization

All prescriptions for Antimigraine Agents, Other must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antimigraine Agent, Other, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package insert OR a medically accepted indication; **AND**

2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Does not have a history of contraindication to the prescribed medication; **AND**

5. For a calcitonin gene-related peptide (CGRP) antagonist/inhibitor prescribed for the prevention of migraine, all of the following:

   a. Is prescribed the CGRP antagonist/inhibitor by or in consultation with **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),

   b. Has documentation of baseline average number of migraine days and headache days per month,

   c. Has averaged four or more migraine days per month over the previous three months,

   d. Has a diagnosis of migraine with or without aura confirmed according to the current International Headache Society Classification of Headache Disorders,

   e. **One** of the following:

      i. Has a history of therapeutic failure of at least one preventive medication from **two** of the following three classes:
         a) Beta-blockers (e.g., metoprolol, propranolol, timolol),
         b) Antidepressants (e.g., amitriptyline, venlafaxine),
         c) Anticonvulsants (e.g., topiramate, valproic acid, divalproex),

ii. Has a history of contraindication or intolerance to all preventive medications from **all** of the following three classes:

a) Beta-blockers (e.g., metoprolol, propranolol, timolol),
b) Antidepressants (e.g., amitriptyline, venlafaxine),
c) Anticonvulsants (e.g., topiramate, valproic acid, divalproex),

f. Will not be using the requested CGRP antagonist/inhibitor with another CGRP antagonist/inhibitor;

AND

6. For a CGRP antagonist/inhibitor prescribed for a diagnosis of episodic cluster headache, all of the following:

a. Is prescribed the CGRP antagonist/inhibitor by or in consultation with one of the following:

i. A neurologist
ii. A headache specialist who is certified in headache medicine by the UCNS,

b. Has a diagnosis of episodic cluster headache confirmed according to the current International Headache Society Classification of Headache Disorders,

c. Has a history of therapeutic failure, contraindication, or intolerance of at least one other preventive medication recommended by current consensus guidelines for episodic cluster headache (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society),

d. Will not be using the requested CGRP antagonist/inhibitor with another CGRP antagonist/inhibitor;

AND

7. For a non-preferred CGRP antagonist/inhibitor, has a history of therapeutic failure, contraindication, or intolerance to the preferred CGRP antagonists/inhibitors approved or medically accepted for the beneficiary's diagnosis. See the Preferred Drug List for the list of preferred CGRP antagonists/inhibitors at: https://papdl.com/preferred-drug-list; **AND**

8. For ergot alkaloids, **both** of the following:

a. Has a diagnosis of headache based on the current International Headache Society Classification of Headache Disorders
b. Has a history of trial and failure, contraindication, or intolerance to standard first-line abortive medications 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);

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR AN ANTIMIGRAINE AGENT, OTHER:
The determination of medical necessity of a request for renewal of a prior authorization for an Antimigraine Agent, Other that was previously approved will take into account whether the beneficiary:

1. Does not have a history of contraindication to the prescribed medication; **AND**

2. For a CGRP antagonist/inhibitor prescribed for the prevention of migraine, **all** of the following:

    a. **One** of the following:

        i. Has a reduction in the average number of migraine days or headache days per month from baseline
        ii. Has experienced a decrease in severity or duration of migraines from baseline,

    b. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

    c. Is prescribed the CGRP antagonist/inhibitor by or in consultation with **one** of the following:

        i. A neurologist
        ii. A headache specialist who is certified in headache medicine by the UCNS; **AND**

3. For a CGRP antagonist/inhibitor prescribed for a diagnosis of episodic cluster headache, all of the following:

    a. Has documentation of a positive clinical response to the requested medication as evidenced by a reduction in cluster headache frequency from baseline,

    b. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

    c. Is prescribed the CGRP antagonist/inhibitor by or in consultation with one of the following:

        i. A neurologist
        ii. A headache specialist who is certified in headache medicine by the UCNS; **AND**

4. For ergot alkaloids, **all** of the following:

    a. Has experienced an improvement in headache pain control or duration
    b. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature;

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. 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 an Antimigraine Agent, Other. 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 beneficiary.

D. Dose and Duration of Therapy

Requests for prior authorization of Antimigraine Agents, Other will be approved as follows:

1. Initial requests for prior authorization of CGRP antagonists/inhibitors prescribed for the prevention of migraine will be approved for up to 6 months.

2. Renewals of requests for prior authorization of CGRP antagonists/inhibitors prescribed for the prevention of migraine will be approved for up to 12 months.

3. Initial requests for prior authorization of CGRP antagonists/inhibitors prescribed for a diagnosis of episodic cluster headache will be approved for up to 4 months.

4. Renewals of requests for prior authorization of CGRP antagonists/inhibitors prescribed for a diagnosis of episodic cluster headache will be approved for up to 6 months.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

ANTIMIGRAINE AGENTS, OTHER – ACUTE TREATMENTS PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other	

CLINICAL INFORMATION

Drug requested:	Strength & dosage form:	
To request a CGRP inhibitor (e.g., Aimovig, Ajovy, Emgality, etc), please use the Antimigraine, Other – CGRP Inhibitors form.		
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	
Does the beneficiary have any of the following contraindications to the requested medication, including but not limited to the following? *Check all that apply.* ☐currently pregnant or breastfeeding ☐hypertension ☐liver impairment ☐kidney impairment ☐sepsis ☐heart disease (such as peripheral vascular disease, coronary artery disease, ischemic heart disease, and history of MI) ☐cerebrovascular insufficiency	☐Yes ☐No	*Submit documentation.*
Is the beneficiary currently taking any medications that are contraindicated with the requested medication (e.g., strong CYP3A4 inhibitors [e.g., protease inhibitors, azole antifungals, some macrolide antibiotics], peripheral or central vasoconstrictors, MAO inhibitors)?	☐Yes ☐No	*Submit beneficiary's complete current medication list.*
INITIAL Requests		
Does the beneficiary have a diagnosis of headache that is consistent with current International Classification of Headache Disorders (ICHD) criteria?	☐Yes ☐No	*Submit documentation of diagnosis.*
Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? *Check all that apply.* ☐caffeine/analgesic combination (e.g., Excedrin) ☐NSAIDs ☐triptans ☐a combination of an NSAID with a triptan	☐Yes ☐No	*Submit documentation.*
RENEWAL Requests		
Has the beneficiary experienced an improvement in headache pain control or duration since starting the requested medication?	☐Yes ☐No	*Submit documentation.*

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date:

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

ANTIMIGRAINE AGENTS, OTHER – CGRP INHIBITORS PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other	

CLINICAL INFORMATION

Drug requested:	Strength:	Formulation (pen, syringe, etc):	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
Is the medication being prescribed by or in consultation with a headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties or a neurologist?		☐Yes ☐No	*Submit documentation of consultation, if applicable.*

INITIAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐For PREVENTION OF MIGRAINE:
- ☐Averaged 4 or more migraine days per month over the past 3 months
- ☐Tried and failed (or cannot try) other preventive migraine therapies
  - ☐Beta blockers (e.g., metoprolol, propranolol, timolol)
  - ☐Antidepressants (e.g., amitriptyline, venlafaxine)
  - ☐Anticonvulsants (e.g., divalproex, topiramate, valproic acid)

☐For EPISODIC CLUSTER HEADACHE:
- ☐Tried and failed (or cannot try) at least one other preventive medication

☐For a NON-PRFERRED CGRP inhibitor:
- ☐Tried and failed or has a contraindication or intolerance to the preferred CGRP inhibitor(s) approved or medically accepted for the diagnosis (*refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred CGRP inhibitors)*

RENEWAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐For PREVENTION OF MIGRAINE:
- ☐Experienced a decreased number of migraine days or headache days per month since starting the requested medication
- ☐Experienced a decrease in severity or duration of migraines since starting the requested medication

☐For EPISODIC CLUSTER HEADACHE:
- ☐Experienced a decrease in the frequency of episodic cluster headache since starting the requested medication

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date: