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

I. Requirements for Prior Authorization of Migraine Acute Treatment Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Migraine Acute Treatment Agents that meet any of the following conditions must be prior authorized:

1. A prescription for a small molecule calcitonin gene-related peptide (CGRP) receptor antagonist (gepant).
2. A prescription for a serotonin (5-HT) 1F receptor agonist (ditan).
3. A prescription for an ergot alkaloid.
4. A non-preferred Migraine Acute Treatment Agent. See the Preferred Drug List (PDL) for the list of preferred Migraine Acute Treatment Agents at: https://papdl.com/preferred-drug-list.
5. A Migraine Acute Treatment Agent when there is a record of a recent paid claim for another Migraine Acute Treatment Agent (therapeutic duplication).

B. Review of Documentation for Medical Necessity

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

1. For a gepant for the preventive treatment of migraine, see the Migraine Prevention Agents Policy; **OR**
2. **Both** of the following:
   a. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication
   b. Has a diagnosis confirmed according to the current International Headache Society Classification of Headache Disorders;

   AND
3. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
4. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
5. Does not have a contraindication to the prescribed medication; **AND**
6. For a gepant for the acute treatment of migraine, **both** of the following:
   a. **One** of the following:
      i. Has a history of therapeutic failure of at least two (5-HT $_{1B/1D}$) receptor agonists (triptans)
      ii. Has a contraindication or intolerance to the preferred triptans
   b. If currently using a different gepant, **one** of the following:
      i. Will discontinue use of that gepant prior to starting the requested gepant
      ii. Has a medical reason for concomitant use of both gepants that is supported by peer-reviewed literature or national treatment guidelines;

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AND

7. For a ditan, has a history of trial and failure, contraindication, or intolerance to the preferred triptans; **AND**

8. For ergot alkaloids, 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); **AND**

9. For a non-preferred Migraine Acute Treatment Agent, **one** of the following:

   a. For a non-preferred triptan, has a history of therapeutic failure, contraindication, or intolerance to the preferred triptans
   b. For all other non-preferred Migraine Acute Treatment Agents (e.g., gepants, ditans, ergot alkaloids, etc.), has a history of therapeutic failure, contraindication, or intolerance to the preferred Migraine Acute Treatment Agents approved or medically accepted for the beneficiary's diagnosis or indication;

   AND

10. For therapeutic duplication, **one** of the following:

    a. Is being titrated to or tapered from another drug in the same class
    b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

    AND

11. If a prescription for a Migraine Acute Treatment Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account **all** of the following:

    a. Whether the beneficiary is prescribed the requested medication by **one** of the following:
       i. A neurologist
       ii. A headache specialist who is certified in headache medicine by the UCNS,

    b. For the acute treatment of migraine, **both** of the following:

       i. **One** of the following:
          a) The beneficiary is using the requested medication in addition to at least one medication for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody)
          b) The beneficiary has a history of therapeutic failure, contraindication, or intolerance to all preventive migraine medications recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society)

       ii. Has documentation of an evaluation for the overuse of abortive medications, including opioids.

    NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment 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.

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FOR RENEWALS OF PRIOR AUTHORIZATION FOR A MIGRAINE ACUTE TREAMENT AGENT: The determination of medical necessity of a request for renewal of a prior authorization for a Migraine Acute Treatment Agent that was previously approved will take into account whether the beneficiary:

1. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
2. Does not have a contraindication to the prescribed medication; **AND**
3. Has documentation of improvement in headache pain, symptoms, or duration; **AND**
4. If a prescription for a Migraine Acute Treatment Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account **all** of the following:

    a. Whether the beneficiary is prescribed the requested medication by **one** of the following:
        i. A neurologist
        ii. A headache specialist who is certified in headache medicine by the UCNS,

    b. For the acute treatment of migraine, **both** of the following:

        i. **One** of the following:
            a) The beneficiary is using the requested medication in addition to at least one medication for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody)
            b) The beneficiary has a history of therapeutic failure, contraindication, or intolerance to all preventive migraine medications recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society)

        ii. Has documentation of an evaluation for the overuse of abortive medications, including opioids.

    NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment 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.

B. 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 a Migraine Acute Treatment Agent. 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.

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MIGRAINE ACUTE TREATMENT AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/3/2022)*

☐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:

CLINICAL INFORMATION

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

Drug requested:	Strength & dosage form:	
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Please complete either the INITIAL requests or RENEWAL requests section. If the requested prescription exceeds the quantity limits/daily dose limits, also complete the QUANTITY LIMITS/DAILY DOSE LIMITS section on the next page.

INITIAL requests

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

☐For a NON-PREFERRED MIGRAINE ACUTE TREATMENT AGENT
- ☐For a non-preferred TRIPTAN:
  - ☐Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (*refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class)*
- ☐For ALL OTHER non-preferred Migraine Acute Treatment Agents:
  - ☐Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class that are approved or medically accepted for the treatment of the beneficiary's diagnosis (*refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in the Migraine Acute Treatment Agents class)*

☐For a GEPANT/SMALL MOLECULE CGRP INHIBITOR (e.g., Nurtec ODT, Ubrelvy)
- ☐Tried and failed at least 2 triptans (e.g., rizatriptan, sumatriptan, etc.) or has a contraindication or intolerance to triptans

☐For a DITAN/5HT1 RECEPTOR AGONIST (e.g., Reyvow)
- ☐Tried and failed or has a contraindication or intolerance to the preferred triptans (*refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class)*

☐For an ERGOT ALKALOID (e.g., Cafergot, D.H.E., Migranal, etc.)
- ☐Tried and failed or has a contraindication or intolerance to the following:
  - ☐caffeine/analgesic combination (e.g., Excedrin)
  - ☐NSAIDs
  - ☐triptans
  - ☐a combination of an NSAID with a triptan
  - ☐other: _____

RENEWAL requests

Has the beneficiary experienced an improvement in headache pain, symptoms, and/ or duration since starting the requested medication?	☐Yes ☐No *Submit documentation.*

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QUANTITY LIMITS/DAILY DOSE LIMITS requests

All requests that exceed the quantity limits/daily dose limits require prior authorization.

Is the requested medication prescribed by a neurologist or specialist certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)?	☐Yes ☐No
Is the requested quantity/dose/frequency supported by current medical compendia and/or peer-reviewed medical literature?	☐Yes ☐No *Submit documentation.*

For ACUTE TREATMENT OF MIGRAINE, check all that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each:

☐Was evaluated for the overuse of abortive headache medications (e.g., opioids, triptans, butalbital, etc.)

☐Will be using the requested medication with at least one medication for migraine prevention – specify:

- ☐anticonvulsant (e.g., topiramate, valproate derivative)
- ☐antidepressant (e.g., SNRI, TCA)
- ☐other: _____
- ☐beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐CRGP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)

☐Tried and failed preventive migraine medications – specify:

- ☐anticonvulsant (e.g., topiramate, valproate derivative)
- ☐antidepressant (e.g., SNRI, TCA)
- ☐other: _____
- ☐beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐CRGP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)

☐Has an intolerance or a contraindication to preventive migraine medications – specify:

- ☐anticonvulsant (e.g., topiramate, valproate derivative)
- ☐antidepressant (e.g., SNRI, TCA)
- ☐other: _____
- ☐beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐CRGP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date: