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

I. Requirements for Prior Authorization of Migraine Prevention Agents

A. Prescriptions That Require Prior Authorization

All prescriptions for Migraine Prevention Agents must be prior authorized.

B. Review of Documentation for Medical Necessity

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

1. For a small molecule calcitonin gene-related peptide (CGRP) receptor antagonist (gepant) for the acute treatment of migraine, see the Migraine Acute Treatment Agents Policy; **OR**
2. 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; **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 Migraine Prevention Agent prescribed for the prevention of migraine, **all** of the following:
    a. Is prescribed the Migraine Prevention Agent 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 contraindication or intolerance that prohibits a trial 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);

AND

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7. For a Migraine Prevention Agent prescribed for a diagnosis of episodic cluster headache, **all** of the following:
   a. Is prescribed the Migraine Prevention Agent 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 documented 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);

   AND

8. If currently using a Migraine Prevention Agent for the preventive treatment of migraine or the treatment of episodic cluster headaches, **one** of the following:
   a. Will discontinue use of that Migraine Prevention Agent prior to starting the requested Migraine Prevention Agent
   b. Has a medical reason for concomitant use of both Migraine Prevention Agents that is supported by peer-reviewed literature or national treatment guidelines;

   AND

9. For a gepant, if currently using a different gepant, **one** of the following:
   a. Will discontinue use of that gepant prior to starting the requested gepant
   b. Has a medical reason for concomitant use of both gepants that is supported by peer-reviewed literature or national treatment guidelines;

   AND

10. For Nurtec ODT for the prevention of migraine, has a documented history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for the beneficiary's indication; **AND**

11. For a non-preferred Migraine Prevention Agent, has a documented history of therapeutic failure, contraindication, or intolerance to the preferred Migraine Prevention Agents approved or medically accepted for the beneficiary's diagnosis or indication. See the Preferred Drug List (PDL) for the list of preferred Migraine Prevention Agents at: https://papdl.com/preferred-drug-list

    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 A MIGRAINE PREVENTION AGENT: The determination of medical necessity of a request for renewal of a prior authorization for a Migraine Prevention 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**

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3. Is prescribed the Migraine Prevention Agent by or in consultation with **one** of the following:
   a. A neurologist
   b. A headache specialist who is certified in headache medicine by the UCNS;
   AND

4. For a Migraine Prevention Agent prescribed for the prevention of migraine, **one** of the following:
   a. Has a reduction in the average number of migraine days or headache days per month from baseline
   b. Experienced a decrease in severity or duration of migraines from baseline;
   AND

5. For a Migraine Prevention Agent prescribed for a diagnosis of episodic cluster headache, has documentation of a positive clinical response to the requested medication as evidenced by a reduction in cluster headache frequency from baseline; **AND**

6. For Nurtec ODT for the prevention of migraine, has a documented history of therapeutic failure, contraindication, or intolerance to the preferred CGRP mAbs approved or medically accepted for the beneficiary's indication; **AND**

7. For a non-preferred Migraine Prevention Agent, has a documented history of therapeutic failure, contraindication, or intolerance to the preferred Migraine Prevention Agents approved or medically accepted for the beneficiary's diagnosis or indication. See the Preferred Drug List (PDL) for the list of preferred Migraine Prevention Agents at: https://papdl.com/preferred-drug-list

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 a Migraine Prevention 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.

D. Dose and Duration of Therapy

Requests for prior authorization of Migraine Prevention Agents will be approved as follows:

1. Initial requests for prior authorization of Migraine Prevention Agents prescribed for the prevention of migraine will be approved for up to 6 months.
2. Renewals of requests for prior authorization of Migraine Prevention Agents prescribed for the prevention of migraine will be approved for up to 12 months.
3. Initial requests for prior authorization of Migraine Prevention Agents prescribed for a diagnosis of episodic cluster headache will be approved for up to 4 months.
4. Renewals of requests for prior authorization of Migraine Prevention Agents prescribed for a diagnosis of episodic cluster headache will be approved for up to 6 months.

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MIGRAINE PREVENTION AGENTS 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:

CLINICAL INFORMATION

Drug requested:	Strength:	Formulation (pen, syringe, tablet, 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 medications
  - ☐Anticonvulsants (e.g., divalproex, topiramate, valproic acid)
  - ☐Antidepressants (e.g., amitriptyline, venlafaxine)
  - ☐Beta blockers (e.g., metoprolol, propranolol, timolol)

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

☐For NURTEC ODT (rimegepant) for PREVENTION OF MIGRAINE:
- ☐Tried and failed (or cannot try) the preferred CGRP monoclonal antibodies approved or medically accepted for the diagnosis (*refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Migraine Prevention Agents)*

☐For a NON-PREFERRED Migraine Prevention Agent:
- ☐Tried and failed or has a contraindication or intolerance to the preferred Migraine Prevention Agents approved or medically accepted for the diagnosis (*refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Migraine Prevention Agents)*

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 fewer average 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 reduction in the frequency of episodic cluster headache since starting the requested medication

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date: