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Pharmacy Policy

Calcitonin-Gene Related Peptide Antagonist (CGRP)

Policy Number: 9.205
Revision Number: R1
Version Effective Date: 1/1/2021

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan	**Boston Medical Center HealthNet Plan**
☒ New Hampshire Medicaid	☐ 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

Products Affected:

- **Aimovig (Erenumab-aooe)[NP]**
- **Ajovy (fremanezumab-vfrm)**
- **Emgality (galcanezumab-gnlm)**

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

Covered Use	FDA approved indications
Exclusion Criteria	Concomitant use with Botox
Required Medical Information	Documentation of the following: 1. **One** of the following diagnosis:

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

NP: Non-Preferred

	a. Diagnosis of episodic migraines with prescriber attestation that member has a greater than 4 migraine days per month AND less than 15 headache days per month; **OR** b. Diagnosis of chronic migraines with prescriber attestation that member has a 15 or more headache days per month; **AND** 2. Member has tried, failed (trial period of at least 3 months per therapy) or contraindicated to, at least **THREE** of the following: i. Beta blockers: metoprolol, propranolol, timolol, atenolol, nadolol, nebivolol, pindolol ii. Antidepressants: amitriptyline, venlafaxine iii. Anticonvulsants: carbamazepine, divalproex, valproic acid, topiramate iv. Alpha adrenagic agonists: clonidine or guanfacine v. ACE-inhibitors: lisinopril vi. Angiotensin receptor blockers: candesartan vii. Triptans: frovatriptan, naratriptan, zolmitriptan viii. Botox (for chronic migraine only); **AND** 3. If the request is for a non-preferred agent (See Appendix A), trial and failure of 1 Preferred product is required prior to Non-Preferred products; **AND** 4. Product will not be used concomitantly with Botox
Age Restriction	Member is over 18 years of age
Prescriber Restriction	Prescribed by or in consultation with a neurologist, pain specialist, or physician certified in headache medicine.
Coverage Duration	Initial: 6 months Reauthorization:1 year
Other criteria	Reauthorization: 1. Prescriber attests that patient has experienced a positive response to therapy as documented by reduction in headache frequency or improvement of functional ability.

Appendix A:

CENTRAL NERVOUS SYSTEM – CALCITONIN GENE-RELATED PEPTIDE INHIBITORS	
PREFERRED	**NON-PREFERRED**
• Ajovy • Emgality	• Aimovig

Applicable Coding:

Clinical Background Information and References

1. Aimovig (erenumab-aooe) [prescribing information]. Thousand Oaks, CA: Amgen Inc; May 2018.
2. Ajovy (fremanezumab-vfrm) [prescribing information]. North Wales, PA: Teva Pharmaceuticals USA, Inc. September 2018
3. Emgality (galcanezumab-gnlm) [prescribing information]. Indianapolic, IN: Eli Lilly and Company. September 2018
4. Hayes Medical Technology Directory. Botulinum Toxin Treatment for Migraine Headache. Winifred Hayes, Inc. September 22, 2011. Updated October 15, 2013
5. 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.

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

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, NH DHHS

Next Review Date

2021

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.