Louisiana Medicaid

~~CGRP (~~Calcitonin Gene-Related Peptide (CGRP) Antagonists

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request authorization for CGRP (Calcitonin Gene-Related Peptide) antagonists.

Additional Point-of-Sale edits may apply.

~~Requests will be considered for initial approval if all of the following criteria are met:~~Approval Criteria

- The recipient is 18 years of age or older on the date of the request; **AND**
- The requested medication has been prescribed by, or in consultation with, a neurologist or pain specialist; **AND**
- The recipient has been evaluated and does not have medication overuse headache; **AND**
- The dosage and administration follows prescribing information for the diagnosis being treated; **AND**
- For ~~-~~**ALL** CGRP Antagonists, **the following is true and stated on the request**:
  - The patient has a diagnosis based on documented history of **ONE** of the following:
    - episodic migraine <15 headache days per month; **OR**
    - chronic migraine ≥15 headache days per month; **AND**
  - The patient has a history of migraines for at least 3 months; **AND**
  - The patient failed ~~-~~treatment with an adequate trial (3 months each) of at least **TWO** standard prophylactic pharmacologic therapies for migraine, or has an intolerance or contraindication to standard prophylactic therapies (e.g., beta blockers, antidepressants, divalproex sodium or topiramate); **OR**
- For galcanezumab-gnlm (Emgality™), **the following is true and is stated on the request**:
  - The recipient has a diagnosis based on documented history of episodic cluster headaches; **AND**
  - The recipient is in an active cluster period; **AND**
  - The recipient has failed treatment with **AT LEAST ONE** triptan indicated for the treatment of cluster headaches (unless contraindicated); **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has a *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated; **AND**
- By submitting the authorization request, the prescriber attests to the following:
  - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
  - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**

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- The recipient has no concomitant drug therapies or disease states that limit the use of CGRP antagonists and will not receive CGRP antagonists in combination with any medication that is contraindicated or not recommended per FDA labeling.

Requests to continue treatment with CGRP antagonists will be considered for approval if all of the following criteria are met:Reauthorization Criteria

- The recipient continues to meet initial criteria; **AND**
- The following **is true and stated on the request**:
  - The recipient continues to be monitored for medication overuse headache; **AND**
  - There is documentation evidence of a positive clinical response to CGRP antagonist therapy.

Duration of initial Initial and reauthorization Reauthorization approvalApproval: 12 months

Point-of-Sale Quantity Limits for CGRP Antagonists

Medication	Quantity
erenumab-aooe (*Aimovig*®) 70mg, 140mg single-dose syringe	3 single-dose syringe/90days
fremanezumab-vfrm (*Ajovy*®) 225mg single-dose syringe	3 (225mg) single-dose syringe/90 days
galcanezumab-gnlm (*Emgality*®) 100 mg single-dose pen/syringe	3 single-dose syringes/30 days
galcanezumab-gnlm (*Emgality*®) 120 mg single-dose pen/syringe	7 single-dose syringes/180 days

References:

Aimovig (erenumab-aooe) [prescribing information]. Thousand Oaks, CA: Amgen Inc; 2019April 2020. Retrieved from https://www.pi.amgen.com/~/media/amgen/repositorysites/pi-amgen-com/aimovig/aimovig_pi_hcp_english.ashx

Ajovy (fremanezumab-vfrm) [prescribing information]. North Wales, PA: Teva Pharmaceuticals; 2019January 2020. Retrieved from https://www.ajovyhcp.com/globalassets/ajovy/ajovy-pi.pdf

Emgality (galcanezumab-gnlm) [prescribing information]. Indianapolis, IN: Eli Lilly and Company; December 2019. Retrieved from http://uspl.lilly.com/emgality/emgality.html#s4

https://www.emgality.com/hcp/cluster/efficacy

ICHD-3.org. (2019). [online] Available at: https://ichd-3.org/wp-content/uploads/2018/01/The-International-Classification-of-Headache-Disorders-3rd-Edition-2018.pdf [Accessed 26 Jun. 2019].

Revision	Date
Added wording for new indication, strength and quantity limit for Emgality®	November 2019
Removed POS information, formatting changes, updated references	July 2020

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