Louisiana Medicaid
Pain Management – Antimigraine Agents – Triptans

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request:

- ~~p~~Prior authorization for non-preferred antimigraine triptans; **OR**
- Clinical authorization for lasmiditan (Reyvow®).

Additional Point-of-Sale edits may apply.

~~NOTE:~~ *Some medications in this therapeutic category may have* ***Black Box Warnings*** *and/or may be subject to* ***Risk Evaluation and Mitigation Strategy (REMS)*** *under FDA safety regulations. Please refer to individual prescribing information for details.*

Non-Preferred Antimigraine Triptans

Approval Criteria for Initial and Reauthorization Requests ~~for Non-Preferred Antimigraine Triptans~~

ALL of the following are required:

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- The requested medication has been prescribed for an approved diagnosis (if applicable); **AND**
- Previous use of a preferred product - **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 *documented contraindication(s)* to 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**
  - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Duration of Initial and ~~A~~Rea~~u~~thorization Approval: 12 months

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Lasmiditan (Reyvow®)

Approval Criteria for Initial and Reauthorization Requests

- The recipient has a diagnosis of migraine, with or without aura; **AND**
- The requested medication is being used to treat moderate to severe pain associated with acute migraine, which is **stated on the request**; **AND**
- The recipient has had a trial of and inadequate response or intolerance to **TWO** oral triptans (at least one must be preferred; names of triptans and trial dates must be **stated on the request**); **AND**
- Previous use of a preferred product - **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 *documented contraindication(s)* to 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**
  - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Duration of initial approval: 6 months
Duration of reauthorization approval: 12 months

References

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Revision	Date
Single PDL Implementation	May 2019
Separated “Select Therapeutic Classes Not Established” into individual therapeutic class documents	November 2019
Added Reyvow®, formatting changes	TBD

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