Louisiana Medicaid
Zavegepant (Zavzpret™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for zavegepant (Zavzpret™).

Additional Point-of-Sale edits may apply.

*This agent 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.*

Approval Criteria

- The recipient is 18 years of age or older on the date of the request; **AND**
- 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**
- If the request is for a non-preferred agent **- ONE** of the following is required: (See Pain Management – Antimigraine Agents – Calcitonin Gene-Related Peptide (CGRP) Antagonists on the PDL/NPDL for list of preferred agents)
    - 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 dosage and administration follow prescribing information for the diagnosis being treated; **AND**
    - The requested medication will not be used concomitantly with preventive medication that acts on the CGRP pathway; **AND**
    - 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 CGRP antagonists and will not receive CGRP antagonists in combination with any medication that is contraindicated or not recommended per FDA labeling.

Duration of initial approval: 6 months

Reauthorization Criteria

- The recipient continues to meet initial criteria; **AND**
- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of reauthorization approval: 12 months

Reference

Zavzpret (zavegepant) [package insert]. New York, NY: Pfizer Labs; March 2023. https://labeling.pfizer.com/ShowLabeling.aspx?id=19471

Revision / Date	Implementation Date
Policy Created / July 2023	January 2024