Louisiana Medicaid
Atogepant (Qulipta™)

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

Additional Point-of-Sale edits may apply.

*This agent may have a **Black Box Warning** and 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 episodic migraine; **AND**
- The recipient failed treatment with an adequate trial (3 months each) of at least **TWO** standard prophylactic pharmacologic therapies for migraine (e.g., beta blockers, antidepressants, divalproex sodium or topiramate) (**Medication names and dates must be stated on the request**); **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 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

Qulipta (atogepant) [package insert]. Dublin, Ireland: Allergan Pharmaceuticals; October 2021. https://www.rxabbvie.com/pdf/qulipta_pi.pdf

Revision / Date	Implementation Date
Policy created / October 2021	April 2022