Louisiana Medicaid
Pain Management – Antimigraine Agents – Calcitonin Gene-Related Peptide (CGRP) Antagonists

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for calcitonin gene-related peptide (CGRP) antagonists.

Additional Point-of-Sale edits may apply.

*These agents 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 for Erenumab-aooe (Aimovig®), Fremanezumab-vfrm (Ajovy®) or Galcanezumab-gnlm (Emgality®)

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has been evaluated and does not have medication overuse headache, and this is **stated on the request**; **AND**
- The dosage and administration follow prescribing information for the diagnosis being treated; **AND**
- 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**
- 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.

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 evidence of a positive clinical response to CGRP antagonist therapy.

Duration of initial and reauthorization approval: 12 months

Atogepant (Qulipta™)

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

Eptinezumab-jjmr (Vyepti™)

Approval Criteria

- The recipient is 18 years of age or older on the date of the request; **AND**
- For eptinezumab-jjmr (Vyepti™), the following is true and is **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); **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 is **NOT** being used for the acute treatment of migraine; **AND**
  - The dosage and administration follow prescribing information for the diagnosis being treated; **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 the requested medication and will not receive the requested medication in combination with any medication that is contraindicated or not recommended per FDA labeling.

Reauthorization Criteria

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

Duration of initial and reauthorization approval: 12 months

Rimegepant (Nurtec® ODT)

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**
- **ONE** of the following is true (names of medications and trial dates must be **stated on the request**):
    - If the requested medication is being used to treat moderate to severe pain associated with acute migraine, then the recipient has had a trial of and inadequate response or intolerance to **TWO** ~~oral~~ triptans (at least one must be preferred); **OR**
    - If the requested medication is being used as preventive treatment of episodic migraines, then the recipient had treatment failure of or intolerance to a preferred injectable calcitonin gene-related peptide (CGRP) monoclonal antibody (e.g., Ajovy®, Emgality®)~~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)~~; **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 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

Ubrogepant (Ubrelvy®)

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:
  - 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

References

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Revision / Date	**Implementation Date**
Added wording for new indication, strength and quantity limit for Emgality® / July 2019	November 2019
Removed POS information, formatting changes, updated references / July 2020	July 2020
Added Nurtec™ ODT, Ubrelvy® and Vyepti® / July 2020	August 2020
Updated references, formatting changes / May 2021	July 2021
Updated indication for Nurtec® ODT, removed prescriber specialty, updated references, formatting changes / June 2021	January 2022
Combined Qulipta™ with current criteria, updated references / May 2022	July 2022
Modified previous use criteria for Nurtec® ODT, updated references / November 2022	April 2023