PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
ANTIMIGRAINE AGENTS, OTHER

Proposed Effective Date: January 1, 2020

Revisions are noted with a ~~strikethrough~~ for deletions and **bold and underline** for additions.

I. Requirements for Prior Authorization of Antimigraine Agents, Other

A. Revisions to Prescriptions That Require Prior Authorization

~~Prescriptions for Antimigraine Agents, Other that meet any of the following conditions must be prior authorized:~~

All prescriptions for Antimigraine Agents, Other must be prior authorized.

1. ~~A prescription for a preferred or non-preferred Antimigraine Agent, Other, regardless of the quantity prescribed.~~ See the Preferred Drug List (PDL) for the list of preferred Antimigraine Agents, Other at: https://papdl.com/preferred-drug-list.

2. ~~A prescription for an Antimigraine Agent, Other with a prescribed quantity that exceeds the quantity limit. See Quantity Limits for the list of drugs with quantity limits~~ **The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available** at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm.

B. Revisions to Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antimigraine Agent, Other, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA) approved package insert OR a medically accepted indication; **AND**

2. Is age-appropriate according to FDA-approved package labeling, ~~or~~ nationally recognized compendia**, or peer-reviewed medical literature**; **AND**

3. Is prescribed a dose that is consistent with FDA-approved package labeling, ~~or~~ nationally recognized compendia**, or peer-reviewed medical literature**; **AND**

4. Does not have a history of contraindication to the prescribed medication; **AND**

5. For calcitonin gene-related peptide (CGRP) antagonists/inhibitors, **all** of the following:

   a. Is prescribed the CGRP antagonist/inhibitor by or in consultation with a neurologist or headache specialist,

   b. Has documentation of baseline average number of migraine days and headache days per month,

c. Has averaged four or more migraine days per month over the previous three months,

d. Has a diagnosis of migraine with or without aura confirmed according to the current International Headache Society Classification of Headache Disorders,

e. **One** of the following:

   i. Has a documented history of therapeutic failure of at least one preventive medication from ~~each~~ **two** of the following three classes:

      a) Beta-blockers (e.g. metoprolol, propranolol, timolol),
      b) Antidepressants (e.g. amitriptyline, venlafaxine),
      c) Anticonvulsants (e.g. topiramate, valproic acid, divalproex),

   ii. Has a documented history of contraindication or intolerance to all preventive medications from ~~each~~ **all** of the following three classes:

      a) Beta-blockers (e.g. metoprolol, propranolol, timolol),
      b) Antidepressants (e.g. amitriptyline, venlafaxine),
      c) Anticonvulsants (e.g. topiramate, valproic acid, divalproex),

f. Will not be using the prescribed CGRP antagonist/inhibitor concomitantly with botulinum toxin,

g. For non-preferred CGRP antagonists/inhibitors, has a documented history of therapeutic failure, contraindication, or intolerance to the preferred CGRP antagonists/inhibitors;

AND

6. For ergot alkaloids, **both** of the following:

   a. Has a diagnosis of headache based on the current International Headache Society Classification of Headache Disorders

   b. Has a documented history of trial and failure, contraindication, or intolerance to standard first-line abortive medications based on headache classification as recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology or American Academy of Family Physicians);

AND

7. If a prescription for an Antimigraine Agent, Other is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR AN ANTIMIGRAINE AGENT, OTHER: The determination of medical necessity of a request for renewal of a prior authorization for an Antimigraine Agent, Other that was previously approved will take into account whether the beneficiary:

1. For CGRP antagonists/inhibitors, **all** of the following:

   a. **One** of the following:

      i. Has a reduction in the average number of migraine days or headache days per month from baseline
      ii. Has experienced a decrease in severity or duration of migraines,

   b. Is prescribed the CGRP antagonist/inhibitor by or in consultation with a neurologist or headache specialist,

   c. Is prescribed a dose that is consistent with FDA-approved package labeling, ~~or~~ nationally recognized compendia**, or peer-reviewed medical literature**,

   d. Does not have a history of contraindication to the prescribed medication;

   AND

2. For ergot alkaloids, **all** of the following:

   a. Has experienced an improvement in headache pain control or duration,

   b. Is prescribed a dose that is consistent with FDA-approved package labeling, ~~or~~ nationally recognized compendia**, or peer-reviewed medical literature**,

   c. Does not have a history of contraindication to the prescribed medication;

   AND

3. If a prescription for an Antimigraine Agent, Other is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

   NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be

approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antimigraine Agent, Other. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

Requests for prior authorization of Antimigraine Agents, Other will be approved as follows:

1. Initial requests for prior authorization of CGRP antagonists/inhibitors will be approved for up to 4 months of therapy.

2. Renewals of requests for prior authorization of CGRP antagonists/inhibitors will be approved for up to 6 months.

E. References

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12. International Headache Society. Headache Classification Committee of the International Headache Society (IHS): The International Classification of Headache Disorders, 3rd edition. Cephalalgia. 2018; Vol. 38(1) 1-211.
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