CRITERIA FOR PRIOR AUTHORIZATION

Migraine Acute Treatment Agents

BILLING CODE TYPE

For drug coverage and provider type information, see the KMAP Reference Codes webpage.

MANUAL GUIDELINES

Prior authorization will be required for all current and future dose forms available. All medication-specific criteria, including drug-specific indication, age, and dose for each agent is defined in Table 1 below.

| Celecoxib (Elyxyb™) |
| Lasmiditan (Reyvow™) |
| Rimegepant (Nurtec™) |
| Ubrogepant (Ubrelvy™) |

GENERAL CRITERIA FOR INITIAL PRIOR AUTHORIZATION: (must meet all of the following)

- Must be approved for the indication, age, and not exceed dosing limits listed in Table 1.
- Patient must not have any unresolved/unaddressed red flag headache symptoms (examples listed in Table 3).³,⁴
- For all agents listed, the preferred PDL drug, which treats the PA indication, is required unless the patient meets the non-preferred PDL PA criteria.
- Patient has a diagnosis of migraines that meet ICHD-3 criteria.¹
- Patient must have <2 migraines per week.²⁴ If a patient has ≥2 migraines²⁴ per week or ≥4 migraines per month¹, the patient must be actively on prophylactic treatment.
- Prescriber has determined that the pain intensity of the patient’s migraine attacks is moderate or severe.
- Patient must have experienced an inadequate response after a trial (at least 2 weeks) of 2 different triptans at a maximum tolerated dose, OR have a documented intolerance or contraindication to all agents within this class listed in Table 2.²⁶
  - Prescriber must provide details of all previous medication trials. Documentation must include the medication name(s), trial date(s) and outcome(s) of the trial (i.e. inadequate response, intolerance or contraindication).
- Patient must have a baseline assessment on one of the following:
  - Migraine Treatment Optimization Questionnaire [mTOQ-5]²,⁷
  - Migraine Disability Assessment Tool [MIDAS]

CRITERIA FOR RENEWAL: (must meet all of the following)

- Dose must not exceed limit in Table 1.
- Patient must meet all of the following:
  - Migraines occurring < 2 times per week and < 4 times per month or actively on prophylactic therapy.²⁴
    - For patients who continue having ≥2 migraines per week or ≥4 migraines per month²⁴, prescriber must provide details of how prophylactic treatment has been optimized since last approval.
  - Patient must have a 50% improvement in one of the following:
    - mTOQ-5
    - MIDAS
- The patient has not required the addition of any other acute treatment agent used for migraine headache.²

LENGTH OF APPROVAL (INITIAL AND RENEWAL): 6 months
APPROVED PA Criteria

For drugs that have a current PA requirement, but not for the newly approved indications, for other FDA-approved indications, and for changes to age requirements not listed within the PA criteria:

- The PA request will be reviewed based upon the following package insert information: Indication, Age, Dose, and any pre-requisite treatment requirements for that indication.

Length of Approval (Initial and Renewal): 6 months

Table 1. FDA-approved age and dosing limits for Migraine Acute Treatment Agents.8-11

<table>
<thead>
<tr>
<th>Agents</th>
<th>Indication(s)</th>
<th>Age</th>
<th>Dosing Limits*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rimegepant (Nurtec)</td>
<td>Acute treatment of migraine</td>
<td>≥18 years</td>
<td>75 mg orally once in 24 hours.</td>
</tr>
<tr>
<td>Ubrogepant (Ubrely)</td>
<td>Acute treatment of migraine</td>
<td>≥18 years</td>
<td>200 mg orally per 24 hours.</td>
</tr>
<tr>
<td><strong>COX-2 Selective Nonsteroidal Anti-inflammatory Drug (NSAID)</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Celecoxib (Elyxyb)</td>
<td>Acute treatment of migraine</td>
<td>≥18 years</td>
<td>120 mg orally once in 24 hours.</td>
</tr>
<tr>
<td><strong>Serotonin 5-HT1F Receptor Agonist</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lasmiditan (Reyvow™)</td>
<td>Acute treatment of migraine</td>
<td>≥18 years</td>
<td>One dose (50 mg, 100 mg, 200 mg) orally once in 24 hours.</td>
</tr>
</tbody>
</table>

* For a maximum of 4 doses per month.1,3,6

Table 2. Prior Acute Migraine Therapies.2-4

<table>
<thead>
<tr>
<th>Triptans</th>
<th>Combination triptans and NSAIDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almotriptan (Axert)</td>
<td>Sumatriptan/naproxen (Treximet)</td>
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<tr>
<td>Eletriptan (Relpax)</td>
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<tr>
<td>Frovatriptan (Frova)</td>
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<tr>
<td>Naratriptan (Amerge)</td>
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<tr>
<td>Rizatriptan (Maxalt)</td>
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</tr>
<tr>
<td>Sumatriptan (Imitrex)</td>
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<tr>
<td>Zolmitriptan (Zomig)</td>
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</tbody>
</table>

Table 3. Examples of Red Flag Headache Symptoms3,4

- Change in headache pattern
- Neurologic signs or seizures
- New onset after age 50
- Persistent headache after Valsalva maneuver or exertion
- Progressively increasing severity
- Symptoms of systemic disorders (i.e. fever, hypertension, myalgia, weight loss)
- “Thunderclap” headache (maximum severity at onset)

Notes:

Reyvow Tablets are available in two strengths: 50 mg, 100 mg.9

The recommended dose of Reyvow is 50 mg, 100 mg, or 200 mg taken orally, as needed. No more than one dose should be taken in 24 hours. A second dose of Reyvow has not been shown to be effective for the same migraine attack. The safety of treating an average of more than 4 migraine attacks in a 30-day period has not been established.9
References:


8. Reyvow (lasmiditan) [prescribing information]. Indianapolis, IN: Lilly USA, LLC; July 2020.


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