UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for CGRP

Program	Prior Authorization
Medication	Aimovig (erenumab), fremanezumab, galcanezumab
Issue Date	3/2018
Pharmacy and Therapeutics Approval Date	3/2018
Effective Date	5/2018

1. Background:

Pending

2. Coverage Criteria:

A. Episodic Migraine

1. Initial Therapy

a. **CGRP** will be approved based upon **all** of the following criteria:

(1) Diagnosis of episodic migraines with **both** of the following:

(a) Less than 15 headache days per month
(b) Patient has 4 to 14 migraine days per month

-AND-

(2) Prescribed by or in consultation with one of the following specialists:

(a) Neurologist
(b) Pain Specialist

-AND-

(3) History of failure (after a trial of at least two months), contraindication, or intolerance to **two** of the following prophylactic therapies from the list below:

(a) amitriptyline (Elavil)
(b) atenolol (Tenormin)

(c) divalproex sodium (Depakote/Depakote ER)
(d) metoprolol (Lopressor/Toprol XL)
(e) nadolol (Corgard)
(f) propranolol (Inderal)
(g) timolol (Blocadren)
(h) topiramate (Topamax)
(i) venlafaxine (Effexor)

Authorization will be issued for 3 months.

2. Reauthorization

a. **CGRP** will be approved based on **both** of the following criteria:

(1) Prescribed by or in consultation with one of the following specialists:

(a) Neurologist
(b) Pain Specialist

-AND-

(2) Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

Authorization will be issued for 12 months.

B. Chronic Migraine

1. Initial Therapy

a. **CGRP** will be approved based upon **all** of the following criteria:

(1) Diagnosis of chronic migraines with **both** of the following:

(a) Greater than or equal to 15 headache days per month
(b) Greater than or equal to 8 migraine days per month

-AND-

(2) Prescribed by or in consultation with one of the following specialists:

(a) Neurologist
(b) Pain Specialist

-AND-

(3) History of failure (after a trial of at least two months), contraindication, or intolerance to **two** of the following prophylactic therapies from the list below:

(a) amitriptyline (Elavil)
(b) atenolol (Tenormin)
(c) Botox (Onabotulinumtoxin A)
(d) divalproex sodium (Depakote/Depakote ER)
(e) metoprolol (Lopressor/Toprol XL)
(f) nadolol (Corgard)
(g) propranolol (Inderal)
(h) timolol (Blocadren)
(i) topiramate (Topamax)
(j) venlafaxine (Effexor)

Authorization will be issued for 3 months.

2. Reauthorization

a. **CGRP** will be approved based on **both** of the following criteria:

(1) Prescribed by or in consultation with one of the following specialists:

(a) Neurologist
(b) Pain Specialist

-AND-

(2) Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

Authorization will be issued for 12 months.

3. References:

1. International Headache Society (IHS); Headache Classification Committee. The International Classification of Headache Disorders, 3rd edition (beta version). Cephalalgia. 2013; 33: 629-808.
2. Silberstein SD, Holland S, Freitag F, et al. Evidence-based guideline update: pharmacologic treatment for episodic migraine prevention in adults: report of the Quality Standards Subcommittee of the American Academy of Neurology and the American Headache Society. Neurology. 2012 Apr 24;78(17):1337-45.

3. Simpson DM, Hallett M, Ashman EJ, et al. Practice guideline update summary: Botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache: Report of the Guideline Development Subcommittee of the American Academy of Neurology. Neurology. 2016 May 10;86(19):1818-26.

Program	Prior Authorization
Change Control	
Date	Change
3/2018	New Program