Acute Migraine Agents Prior Authorization with Quantity Limit

TARGET AGENT(S)
Reyvow® (lasmiditan)

PROGRAM PRIOR AUTHORIZATION AND QUANTITY LIMIT TARGET AGENTS

Brand (generic)	GPI	Multisource Code	Quantity Limit (per day or as listed)
Reyvow (lasmiditan)			
50 mg tablet	67406540600310	M, N, O, Y	8 tablets / 30 days
100 mg tablet	67406540600320	M, N, O, Y	8 tablets / 30 days

PRIOR AUTHORIZATION AND QUANTITY LIMIT CRITERIA FOR APPROVAL
Initial Evaluation
Target Agent(s) will be approved when ALL of the following are met:

1. ONE of the following:
    A. The patient has a diagnosis of migraine AND ONE of the following:
        i. The requested agent is being used for acute migraine treatment AND ALL of the following:
            1. ONE of the following:
                a. The patient has tried and had an inadequate response to at least one triptan agent
                OR
                b. The patient has an intolerance or hypersensitivity to a triptan agent
                OR
                c. The patient has an FDA labeled contraindication to ALL triptan agents
            AND
            2. The patient will NOT be using the requested agent in combination with another acute migraine agent (i.e., triptan, 5HT-1F, ergotamine, acute CGRP)
            AND
            3. Medication overuse headache has been ruled out

    OR
    B. The patient has another FDA approved indication for the requested agent and route of administration
    OR
    C. The patient has another indication that is supported in compendia for the requested agent and route of administration

    AND
2. ONE of the following:
    A. The patient's age is within FDA labeling for the requested indication for the requested agent
    OR
    B. The prescriber has provided information in support of using the requested agent for the patient's age for the requested indication

    AND
3. The patient does not have any FDA labeled contraindications to the requested agent
    AND
4. ONE of the following:
    A. The requested quantity (dose) does NOT exceed the program quantity limit
    OR
    B. ALL of the following:
        i. The requested quantity (dose) is greater than the program quantity limit
        AND
        ii. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication
        AND
        iii. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit

    OR

C. ALL of the following:
    i. The requested quantity (dose) is greater than the program quantity limit
    AND
    ii. The requested quantity (dose) is greater than the maximum FDA labeled dose for the requested indication
    AND
    iii. The patient has >4 migraine headaches per month AND ONE of the following:
        1. The patient is currently being treated with a migraine prophylactic medication (i.e. anticonvulsants [divalproex, valproate, topiramate], beta blockers [i.e. atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [i.e. amitriptyline, venlafaxine], candesartan, prophylactic CGRP [e.g. Aimovig, Ajovy, Emgality, Vyepti], onabotulinum toxin A [Botox])
        OR
        2. The patient has an intolerance or hypersensitivity to therapy with anticonvulsants, beta blockers, antidepressants, candesartan, prophylactic CGRP, AND onabotulinum toxin A
        OR
        3. The patient has an FDA labeled contraindication to ALL anticonvulsants, beta blockers, antidepressants, candesartan, prophylactic CGRP, AND onabotulinum toxin A
        OR
        4. The prescriber has provided information that the patient's migraine is manageable with acute therapy alone
    AND
    iv. The prescriber has provided information in support of therapy with a higher dose for the requested indication

Compendia Allowed: AHFS, or DrugDex 1 or 2a level of evidence

Length of Approval: 12 months

Renewal Evaluation
Target Agent(s) will be approved when ALL of the following are met:
1. The patient has been approved for the requested agent previously through the Plan's Prior Authorization process
   AND
2. ONE of the following:
   A. The requested agent is being used for acute migraine treatment AND ALL of the following:
      i. The prescriber has provided information indicating improvement in acute migraine management with the requested agent
      AND
      ii. The patient will NOT be using the requested agent in combination with another acute migraine agent (i.e., triptan, 5HT-1F, ergotamine, acute CGRP)
      AND
      iii. Medication overuse headache has been ruled out
   OR
   B. BOTH of the of the following:
      i. The patient has another FDA approved indication, or the patient has another indication that is supported in compendia for the requested agent
      AND
      ii. The patient has had clinical benefit with the requested agent
   AND
3. The patient does NOT have any FDA labeled contraindications to the requested agent
   AND
4. ONE of the following:
   A. The requested quantity (dose) does NOT exceed the program quantity limit
   OR
   B. ALL of the following:

i. The requested quantity (dose) is greater than the program quantity limit
AND
ii. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication
AND
iii. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit

OR

C. ALL of the following:
i. The requested quantity (dose) is greater than the program quantity limit
AND
ii. The requested quantity (dose) is greater than the maximum FDA labeled dose for the requested indication
AND
iii. The patient has >4 migraine headaches per month AND ONE of the following:
1. The patient is currently being treated with a migraine prophylactic medication (i.e. anticonvulsants [divalproex, valproate, topiramate], beta blockers [i.e. atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [i.e. amitriptyline, venlafaxine], candesartan, prophylactic CGRP [e.g. Aimovig, Ajovy, Emgality, Vyepti], onabotulinum toxin A [Botox])
OR
2. The patient has an intolerance or hypersensitivity to therapy with anticonvulsants, beta blockers, antidepressants, candesartan, prophylactic CGRP, AND onabotulinum toxin A
OR
3. The patient has an FDA labeled contraindication to ALL anticonvulsants, beta blockers, antidepressants, candesartan, prophylactic CGRP, AND onabotulinum toxin A
OR
4. The prescriber has provided information that the patient's migraine is manageable with acute therapy alone

AND
iv. The prescriber has provided information in support of therapy with a higher dose for the requested indication

Compendia Allowed: AHFS, or DrugDex 1 or 2a level of evidence

Length of Approval: 12 months