# AvMed

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions**: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

# Injectable Calcitonin Gene-Related Peptide (CGRP) Antagonists

**Drug Requested:** (Select one from below)

| PREFERRED | |
|---|---|
| ❑ **Aimovig®** (erenumab) | ❑ **Emgality®** (galcanezumab) |
| **NON-PREFERRED** | |
| ❑ **Ajovy®** (fremanezumab) ***Member must have tried and failed BOTH preferred agents and meet all PA criteria for approval of Ajovy*** | |

**AvMed Considers the use of concomitant therapy with Calcitonin Gene-Related Peptide Antagonists (CGRP) and Botox to be experimental and investigational, although safety and efficacy of these combinations has been established. In the event a member has an active Botox authorization on file and dual therapy is requested, all subsequent CGRP requests will be reviewed and assessed for medical necessity of combination therapy.**

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member AvMed #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**DEA OR NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Form/Strength**: _____

**Dosing Schedule**: _____ **Length of Therapy:** _____

**Diagnosis:** _____ **ICD Code:** _____

**Weight:** _____ **Date:** _____

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## Recommended Dosing & Quantity Limits:

| Drug | Dose | Quantity Limit |
|---|---|---|
| **Aimovig®** (erenumab) | • **Migraine Prophylaxis**: Initial: 70 mg SC once a month; some members may benefit from 140 mg once a month (given as 2 consecutive 70 mg injections) | • 70 mg/mL (1 mL/30 day)<br>• 140 mg dose (2 mL/30 days)<br>• If using the 140 mg dose, must use the package labeled specifically for 140 mg/mL |
| **Ajovy®** (fremanezumab) | • **Migraine Prophylaxis**: 225 mg SC monthly **or** 675 mg every 3 months | • 225 mg/1.5 mL; 1.5 mL (1 syringe) per 30 days or 4.5 mL (3 syringes) per 90 days |
| **Emgality®** (galcanezumab) | • **Migraine Prophylaxis**: Initial: 240 mg SC as a single loading dose, followed by 120 mg once monthly<br>• **Episodic cluster headache prophylaxis**: 300 mg SC at the onset of the cluster period and then once monthly until the end of the cluster period | • 120 mg/mL; 1 mL (1 auto-injector and prefilled syringe) per 30 days with one time loading dose of 2 mL (2 auto- injectors)<br>• For Episodic Cluster headache diagnosis only: 300 mg dose; 100 mg/mL prefilled syringe |

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval.

## Authorization Criteria

- ❑ Member must be 18 years of age or older
- ❑ Provider has attested to all clinical criteria for **ONE** of the applicable diagnoses below

**DIAGNOSIS:** Please check **ONE** of the applicable diagnoses below

❑ **Chronic & Episodic Migraine Headache Prevention** (All applicable boxes below must be met to qualify)

- ❑ Member must have a diagnosis of Chronic or Episodic Migraine Headache defined by **BOTH** of the following:
  - ❑ Member has ≥ 4 migraine headache days per month
  - ❑ Member must have failed a **2-month** trial of at least one medication from **TWO** different migraine prophylactic classes supported by the American Headache Society/American Academy of Neurology treatment guidelines 2012/2015/2021, Level A and B evidence; ICSI 2013, high quality evidence:
    - ❑ Anticonvulsants (divalproex, valproate, topiramate)
    - ❑ Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
    - ❑ Antidepressants (amitriptyline, venlafaxine)

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- ❑ Member will **NOT** be initiating botulinum toxin headache prophylaxis after starting the requested agent
- ❑ Requested medication will **NOT** be used in combination with Botox or another CGRP inhibitor indicated for migraine prevention
- ❑ **For Ajovy Requests:** Member must have tried and failed **BOTH** preferred agents Aimovig and Emgality **AND** meet all prior authorization criteria for approval of Ajovy

❑ **Episodic Cluster Headaches (Emgality® Only)** (All applicable boxes below must be met to qualify)

- ❑ Member has between one headache every other day and eight headaches per day
- ❑ Member must have failed at least a **1-month** trial of at least **ONE** **generic** standard prophylactic pharmacologic therapy, used to prevent cluster headache and supported by the American Headache Society/American Academy of Neurology treatment guidelines:
  - ❑ Suboccipital steroid injection
  - ❑ Calcium channel blockers (verapamil)
  - ❑ Alkali metal/ Antimanic (lithium)
  - ❑ Anticoagulant (warfarin)
  - ❑ Anticonvulsants (topiramate)

***Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.***

***Previous therapies will be verified through pharmacy paid claims or submitted chart notes.***

***Approved by Pharmacy and Therapeutics Committee:** ~~7/19/2018; 1/10/2022;~~ **8/17/2023**
**REVISED/UPDATED:** ~~3/14/2019; 7/1/2019; 12/30/2019; 6/15/2020; 8/2/2021; 11/8/2021; **11/22/2021** 1/10/2022; 2/24/2022; 6/15/2022; 8/26/2022; 3/2/2023;~~ **9/18/2023**