Calcitonin Gene-Related Peptide (CGRP) Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date **Date of Origin**
05-15-2026

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Qulipta	atogepant tab	10 MG ; 30 MG ; 60 MG	M ; N ; O ; Y	N		
Aimovig	erenumab-aooe subcutaneous soln auto-injector	140 MG/ML ; 70 MG/ML	M ; N ; O ; Y	N		
Ajovy	fremanezumab-vfrm subcutaneous soln auto-inj ; fremanezumab-vfrm subcutaneous soln pref syr	225 MG/1.5ML	M ; N ; O ; Y	N		
Emgality	galcanezumab-gnlm subcutaneous soln auto-injector ; galcanezumab-gnlm subcutaneous soln prefilled syr	100 MG/ML ; 120 MG/ML	M ; N ; O ; Y	N		
Nurtec	rimegepant sulfate tab disint	75 MG	M ; N ; O ; Y	N		
Ubrelvy	ubrogepant tab	100 MG ; 50 MG	M ; N ; O ; Y	N		
Zavzpret	zavegepant hcl nasal spray	10 MG/ACT	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Ubrelvy	Ubrogepant Tab 50 MG	50 MG	16	Tablets	30	DAYS			
Zavzpret	zavegepant hcl nasal spray	10 MG/ACT	8	Devices	30	DAYS			
Aimovig	Erenumab-aooe Subcutaneous Soln Auto-Injector 140 MG/ML	140 MG/ML	1	Injection Device	28	DAYS			
Aimovig	Erenumab-aooe Subcutaneous Soln Auto-Injector 70 MG/ML	70 MG/ML	1	Injection Device	28	DAYS			
Ajovy	Fremanezumab-vfrm Subcutaneous Soln	225 MG/1.5 ML	3	Injection Devices	84	DAYS	4.5 mL= 3 auto-injectors		

© Copyright Prime Therapeutics LLC. April 2026 All Rights Reserved

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
	Auto-inj 225 MG/1.5ML								
Ajovy	Fremanezumab-vfrm Subcutaneous Soln Pref Syr 225 MG/1.5ML	225 MG/1.5 ML	3	Syringes	84	DAYS	4.5 mL= 3 syringes		
Emgality	Galcanezumab-gnlm Subcutaneous Soln Auto-Injector 120 MG/ML	120 MG/ML	1	Injection Device	28	DAYS			
Emgality	Galcanezumab-gnlm Subcutaneous Soln Prefilled Syr 100 MG/ML	100 MG/ML	9	Syringes	180	DAYS			
Emgality	Galcanezumab-gnlm Subcutaneous Soln Prefilled Syr 120 MG/ML	120 MG/ML	1	Syringe	28	DAYS			
Nurtec	Rimegepant Sulfate Tab Disint 75 MG	75 MG	54	Tablets	90	DAYS			
Ubrelvy	Ubrogepant Tab 100 MG	100 MG	16	Tablets	30	DAYS			
Qulipta	Atogepant Tab	10 MG	30	Tablets	30	DAYS			
Qulipta	Atogepant Tab	30 MG	30	Tablets	30	DAYS			
Qulipta	Atogepant Tab	60 MG	30	Tablets	30	DAYS			

ADDITIONAL QUANTITY LIMIT INFORMATION

Wildcard	Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Additional QL Information	Targeted NDCs When Exclusions Exist	Effective Date	Term Date
6770203020D520	Ajovy	Fremanezumab-vfrm Subcutaneous Soln Auto-inj 225 MG/1.5ML	225 MG/1.5 ML	4.5 mL= 3 auto-injectors			
6770203020E520	Ajovy	Fremanezumab-vfrm Subcutaneous Soln Pref Syr 225 MG/1.5ML	225 MG/1.5 ML	4.5 mL= 3 syringes			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Aimovig	erenumab-aooe subcutaneous soln auto-injector	140 MG/ML ; 70 MG/ML	Boeing
Ajovy	fremanezumab-vfrm subcutaneous soln auto-inj ; fremanezumab-vfrm subcutaneous soln pref syr	225 MG/1.5ML	Boeing
Emgality	galcanezumab-gnlm subcutaneous soln auto-injector ; galcanezumab-gnlm subcutaneous soln prefilled syr	100 MG/ML ; 120 MG/ML	Boeing
Nurtec	rimegepant sulfate tab disint	75 MG	Boeing
Qulipta	atogepant tab	10 MG ; 30 MG ; 60 MG	Boeing
Ubrelvy	ubrogepant tab	100 MG ; 50 MG	Boeing
Zavzpret	zavegepant hcl nasal spray	10 MG/ACT	Boeing

© Copyright Prime Therapeutics LLC. April 2026 All Rights Reserved

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Ubrelvy	Ubrogepant Tab 50 MG	50 MG	Boeing
Zavzpret	zavegepant hcl nasal spray	10 MG/ACT	Boeing
Aimovig	Erenumab-aooe Subcutaneous Soln Auto-Injector 140 MG/ML	140 MG/ML	Boeing
Aimovig	Erenumab-aooe Subcutaneous Soln Auto-Injector 70 MG/ML	70 MG/ML	Boeing
Ajovy	Fremanezumab-vfrm Subcutaneous Soln Auto-inj 225 MG/1.5ML	225 MG/1.5ML	Boeing
Ajovy	Fremanezumab-vfrm Subcutaneous Soln Pref Syr 225 MG/1.5ML	225 MG/1.5ML	Boeing
Emgality	Galcanezumab-gnlm Subcutaneous Soln Auto-Injector 120 MG/ML	120 MG/ML	Boeing
Emgality	Galcanezumab-gnlm Subcutaneous Soln Prefilled Syr 100 MG/ML	100 MG/ML	Boeing
Emgality	Galcanezumab-gnlm Subcutaneous Soln Prefilled Syr 120 MG/ML	120 MG/ML	Boeing
Nurtec	Rimegepant Sulfate Tab Disint 75 MG	75 MG	Boeing
Ubrelvy	Ubrogepant Tab 100 MG	100 MG	Boeing
Qulipta	Atogepant Tab	30 MG	Boeing
Qulipta	Atogepant Tab	10 MG	Boeing
Qulipta	Atogepant Tab	60 MG	Boeing

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval

Indication	Preferred Target Agent(s)	Non-Preferred Target Agent(s)	Stand-Alone Target Agent(s)
Chronic Migraine Prophylaxis	Aimovig Ajovy Emgality Qulipta		
Episodic Migraine Prophylaxis	Aimovig Ajovy Emgality Nurtec ODT Qulipta		
Treatment of Episodic Cluster Headaches	Emgality		
Acute Treatment of Migraine	Nurtec ODT Ubrelvy		Zavzpret

© Copyright Prime Therapeutics LLC. April 2026 All Rights Reserved

Module	Clinical 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 requested agent is being used for migraine prophylaxis AND BOTH of the following:
      1. ONE of the following:
         A. The requested agent is eligible for continuation of therapy AND BOTH of the following:

Agents Eligible for Continuation of Therapy
Aimovig
Ajovy
Emgality
Nurtec ODT
Qulipta

            1. The prescriber states the patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days AND is at risk if therapy is changed **AND**
            2. The requested agent and strength is FDA labeled for migraine prophylaxis **OR**
         B. ALL of the following:
            1. ONE of the following:
               A. The patient has had at least 15 headache days per month of migraine-like or tension-like headache for a minimum of 3 months (chronic migraine) **AND** BOTH of the following:
                  1. The patient has had at least 8 migraine headache days per month for a minimum of 3 months **AND**
                  2. The requested agent and strength are FDA labeled for chronic migraine prophylaxis **OR**
               B. ALL of the following:
                  1. The patient has 4-14 monthly migraine days (episodic migraine) **AND**
                  2. The requested agent and strength is FDA labeled for episodic migraine prophylaxis **AND**
                  3. If the request is for Ajovy, then ONE of the following:
                     A. BOTH of the following:
                        1. The patient is between 6-17 years of age **AND**
                        2. The patient weighs at least 45 kg **OR**
                     B. The patient is an adult **AND**
            2. ONE of the following:
               A. The patient has ONE of the following to at least one migraine prophylaxis class (e.g., angiotensin receptor blocker, angiotensin converting enzyme

© Copyright Prime Therapeutics LLC. April 2026 All Rights Reserved

Module	Clinical Criteria for Approval
	inhibitor, anticonvulsant, beta-blocker, calcium channel blocker, tricyclic antidepressant, other antidepressant): 1. A trial and inadequate response after an adequate trial as defined by BOTH of the following: A. The trial length was at least 8 weeks at generally accepted doses **AND** B. The patient was greater than or equal to 80% adherent to the prophylaxis agent during the trial **OR** 2. The patient has an intolerance or hypersensitivity to therapy with at least one migraine prophylaxis class **OR** 3. The patient has an FDA labeled contraindication to ALL migraine prophylaxis agents (e.g., angiotensin receptor blocker, angiotensin converting enzyme inhibitor, anticonvulsant, beta-blocker, calcium channel blocker, tricyclic antidepressant, other antidepressant) **AND** 3. ONE of the following: A. The requested agent is a preferred agent or a stand-alone agent for the requested indication **OR** B. The requested agent is a non-preferred agent for the requested indication AND the patient has ONE of the following: 1. Tried and had an inadequate response to ONE preferred agent for the requested indication **OR** 2. An intolerance or hypersensitivity to ONE preferred agent for the requested indication **OR** 3. An FDA labeled contraindication to ALL preferred agents for the requested indication **AND** 4. If the patient has an FDA labeled indication, then ONE of the following: A. The patient's age is within FDA labeling for the requested indication for the requested agent **OR** B. There is support for using the requested agent for the patient's age for the requested indication **AND** 2. The patient will NOT be using the requested agent in combination with another CGRP agent being used for migraine prophylaxis **OR** B. BOTH of the following: 1. ONE of the following: A. The requested agent is being used for the treatment of episodic cluster headache AND ALL of the following: 1. The patient has had at least 5 cluster headache attacks **AND** 2. The patient has at least two cluster periods lasting 7-365 days **AND** 3. The patient's cluster periods are separated by a pain-free remission period of greater than or equal to 3 months **AND** 4. The patient has ONE of the following: A. Tried and had an inadequate response to ONE prerequisite agent (i.e., verapamil, melatonin, corticosteroids, topiramate, lithium) **OR**

© Copyright Prime Therapeutics LLC. April 2026 All Rights Reserved

Module	Clinical Criteria for Approval
	B. An intolerance or hypersensitivity to ONE prerequisite agent **OR** C. An FDA labeled contraindication to ALL prerequisite agents **AND** 5. The requested agent and strength is FDA labeled for the treatment of episodic cluster headache **OR** B. The requested agent is being used for the acute treatment of migraines AND ALL of the following: 1. The patient has ONE of the following: A. Tried and had an inadequate response to ONE triptan or triptan combination agent **OR** B. An intolerance or hypersensitivity to ONE triptan or triptan combination agent **OR** C. An FDA labeled contraindication to ALL triptan and triptan combination agents **AND** 2. The patient will NOT be using the requested agent in combination with another acute migraine therapy (i.e., 5HT-1F, acute use CGRP, ergotamine) for the requested indication **AND** 3. ONE of the following: A. The requested agent is a preferred agent or a stand-alone agent for the requested indication **OR** B. The requested agent is a non-preferred agent for the requested indication AND the patient has ONE of the following: 1. Tried and had an inadequate response to ONE preferred agent for the requested indication **OR** 2. An intolerance or hypersensitivity to ONE preferred agent for the requested indication **OR** 3. An FDA labeled contraindication to ALL preferred agents for the requested indication **AND** 4. The requested agent and strength is FDA labeled for the acute treatment of migraines **OR** C. The patient has another FDA labeled indication for the requested agent and route of administration **AND** 2. If the patient has an FDA labeled indication, then ONE of the following: 1. The patient's age is within FDA labeling for the requested indication for the requested agent **OR** 2. There is support for using the requested agent for the patient's age for the requested indication **OR** C. The patient has an indication that is supported in compendia for the requested agent and route of administration **AND** 2. The patient does not have any FDA labeled contraindications to the requested agent **Compendia Allowed:** AHFS, or DrugDex 1, 2a, or 2b level of evidence **Length of Approval:** 12 months NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria. **Renewal Evaluation** **Target Agent(s)** will be approved when ALL of the following are met:

© Copyright Prime Therapeutics LLC. April 2026 All Rights Reserved

Module	Clinical Criteria for Approval
	1. The patient has been approved for the requested agent previously through the plan's Prior Authorization process (Note: patients not previously approved for the requested agent will require initial evaluation review) **AND** 2. ONE of the following: A. The requested agent is being used for migraine prophylaxis AND ALL of the following: 1. The patient has had clinical benefit with the requested agent **AND** 2. The patient will NOT be using the requested agent in combination with another CGRP agent being used for migraine prophylaxis **AND** 3. ONE of the following: A. BOTH of the following: 1. The patient has a diagnosis of chronic migraine (defined as at least 15 headache days per month of migraine-like or tension-like headache for a minimum of 3 months prior to migraine prevention therapy) **AND** 2. The requested agent and strength is FDA labeled for chronic migraine **OR** B. ALL of the following: 1. The patient has a diagnosis of episodic migraine (defined as 4-14 monthly migraine days prior to migraine prevention therapy) **AND** 2. The requested agent and strength is FDA labeled for episodic migraine **AND** 3. If the request is for Ajovy, then ONE of the following: A. BOTH of the following: 1. The patient is between 6-17 years of age **AND** 2. The patient weighs at least 45 kg **OR** B. The patient is an adult **OR** B. The requested agent is being used for the treatment of episodic cluster headache AND BOTH of the following: 1. The patient has had clinical benefit with the requested agent **AND** 2. The requested agent and strength is FDA labeled for the treatment of episodic cluster headache **OR** C. The requested agent is being used for the acute treatment of migraines AND ALL of the following: 1. The patient has had clinical benefit with the requested agent **AND** 2. The patient will NOT be using the requested agent in combination with another acute migraine therapy (i.e., 5HT-1F, acute use CGRP, ergotamine) for the requested indication **AND** 3. The requested agent and strength is FDA labeled for the acute treatment of migraines **OR** D. The patient is NOT using the requested agent for migraine prophylaxis, treatment of episodic cluster headache, or acute treatment of migraines AND has had clinical benefit with the requested agent **AND** 3. The patient does NOT have any FDA labeled contraindications to the requested agent **Length of Approval:** 12 months NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	Quantity Limit for Target Agent(s) will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: A. BOTH of the following: 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication **AND**

© Copyright Prime Therapeutics LLC. April 2026 All Rights Reserved

Module	Clinical Criteria for Approval
	2. There is support for therapy with a higher dose for the requested indication **OR** B. BOTH of the following: 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND** 2. There is support for why 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: 1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication **AND** 2. If the requested agent is being used for the acute treatment of migraines, then ONE of the following: A. The patient is currently being treated with a migraine prophylactic medication (e.g., angiotensin receptor blocker, angiotensin converting enzyme inhibitor, anticonvulsant, beta-blocker, calcium channel blocker, tricyclic antidepressant, other antidepressant, prophylactic use CGRP [e.g., Aimovig, Ajovy, Emgality, Nurtec, Qulipta, Vyepti], onabotulinum toxin A [Botox]) **OR** B. The patient has an intolerance or hypersensitivity to therapy with migraine prophylactic medication **OR** C. The patient has an FDA labeled contraindication to ALL migraine prophylactic medications **OR** D. There is support that the patient's migraine is manageable with acute therapy alone **AND** 3. There is support for therapy with a higher dose for the requested indication **Length of Approval**: 12 months NOTE: For agents that require a loading dose for a new start, approve the loading dose based on FDA labeling AND the maintenance dose for the remainder of approval up to 12 months.

© Copyright Prime Therapeutics LLC. April 2026 All Rights Reserved