

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

POLICY REVIEW CYCLE

Effective Date
01-01-2026

Date of Origin

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
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		
Qulipta	atogepant tab	10 MG ; 30 MG ; 60 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	Duratio n	Addtl QL Info	Allowed Exceptions	Targete d NDCs When Exclusi ons Exist
Ubrelvy	Ubrogapant 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			

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
Ajovy	Fremanezumab-vfrm Subcutaneous Soln Auto-inj 225 MG/1.5ML	225 MG/1.5 ML	3	Injection Devices	84	DAYS	4.5 mL= 3 auto-injectors		
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-aoee subcutaneous soln auto-injector	140 MG/ML ; 70 MG/ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Ajovy	fremanezumab-vfrm subcutaneous soln auto-inj ; fremanezumab-vfrm subcutaneous soln pref syr	225 MG/1.5ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Emgality	galcanezumab-gnlm subcutaneous soln auto-injector ; galcanezumab-gnlm subcutaneous soln prefilled syr	100 MG/ML ; 120 MG/ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Nurtec	rimegepant sulfate tab disint	75 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Qulipta	atogepant tab	10 MG ; 30 MG ; 60 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Ubrelvy	ubrogepant tab	100 MG ; 50 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Zavzpret	zavegepant hcl nasal spray	10 MG/ACT	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Ubrelvy	Ubrogepant Tab 50 MG	50 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Zavzpret	zavegepant hcl nasal spray	10 MG/ACT	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Aimovig	Erenumab-aooe Subcutaneous Soln Auto-Injector 140 MG/ML	140 MG/ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Aimovig	Erenumab-aooe Subcutaneous Soln Auto-Injector 70 MG/ML	70 MG/ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Ajovy	Fremanezumab-vfrm Subcutaneous Soln Auto-inj 225 MG/1.5ML	225 MG/1.5ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			2026 ; Topaz ; Whole Foods
Ajovy	Fremanezumab-vfrm Subcutaneous Soln Pref Syr 225 MG/1.5ML	225 MG/1.5ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Emgality	Galcanezumab-gnlm Subcutaneous Soln Auto-Injector 120 MG/ML	120 MG/ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Emgality	Galcanezumab-gnlm Subcutaneous Soln Prefilled Syr 100 MG/ML	100 MG/ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Emgality	Galcanezumab-gnlm Subcutaneous Soln Prefilled Syr 120 MG/ML	120 MG/ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Nurtec	Rimegepant Sulfate Tab Disint 75 MG	75 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Ubrelvy	Ubrogepant Tab 100 MG	100 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ;

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Qulipta	Atogepant Tab	10 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Qulipta	Atogepant Tab	30 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Qulipta	Atogepant Tab	60 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

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		Zavzpret
		Ubrelyvy		
Initial Evaluation				
Target Agent(s) will be approved when BOTH of the following are met:				
<ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The requested agent is being used for migraine prophylaxis AND BOTH of the following: <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The requested agent is eligible for continuation of therapy AND BOTH of the following: 				
Agents Eligible for Continuation of Therapy				
Aimovig				

Module	Clinical Criteria for Approval
	<div data-bbox="235 184 1230 422" style="border: 1px solid black; padding: 5px; margin-bottom: 20px;"> <p>Ajovy</p> <p>Emgality</p> <p>Nurtec ODT</p> <p>Qulipta</p> </div> <ol style="list-style-type: none"> 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 <p>B. ALL of the following:</p> <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 is FDA labeled for chronic migraine prophylaxis OR B. ALL of the following: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 ONE of the following: <ol style="list-style-type: none"> 1. The request is for a BCBS IL Fully Insured, ASO Cost/BBF, HIM, or Non-ERISA ASO/Self-insured Municipalities/Counties member OR 2. BOTH of the following: <ol style="list-style-type: none"> A. ONE of the following: <ol style="list-style-type: none"> 1. The patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR 2. The patient has been diagnosed with stage four advanced, metastatic

Module	Clinical Criteria for Approval
	<p style="text-align: right;">cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer AND</p> <p>B. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR</p> <p>3. The patient is currently being treated with the requested agent and the patient is currently stable on the requested agent OR</p> <p>4. The patient has ONE of the following:</p> <p>A. Tried and had an inadequate response to ONE preferred agent for the requested indication OR</p> <p>B. An intolerance or hypersensitivity to ONE preferred agent for the requested indication OR</p> <p>C. An FDA labeled contraindication to ALL preferred agent(s) for the requested indication OR</p> <p>5. ONE preferred agent was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event OR</p> <p>6. ONE preferred agent is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm OR</p> <p>7. ONE preferred agent is not in the best interest of the patient based on medical necessity OR</p> <p>8. The patient has tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE preferred agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event AND</p> <p>3. If the patient has an FDA labeled indication, then ONE of the following:</p> <p>A. The patient's age is within FDA labeling for the requested indication for the requested agent OR</p> <p>B. There is support for using the requested agent for the patient's age for the requested indication AND</p>

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	<p>2. The patient will NOT be using the requested agent in combination with another CGRP agent being used for migraine prophylaxis OR</p> <p>B. BOTH of the following:</p> <p>1. ONE of the following:</p> <p>A. The requested agent is being used for the treatment of episodic cluster headache AND ALL of the following:</p> <ol style="list-style-type: none"> 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. ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR B. The patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer AND 2. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR B. The patient has ONE of the following: <ol style="list-style-type: none"> 1. Tried and had an inadequate response to ONE prerequisite agent (i.e., verapamil, melatonin, corticosteroids, topiramate, lithium) OR 2. An intolerance or hypersensitivity to ONE prerequisite agent (i.e., verapamil, melatonin, corticosteroids, topiramate, lithium) OR 3. An FDA labeled contraindication to ALL prerequisite agent(s) (i.e., verapamil, melatonin, corticosteroids, topiramate, lithium) AND 5. The requested agent and strength is FDA labeled for the treatment of episodic cluster headache OR <p>B. The requested agent is being used for the acute treatment of migraines AND ALL of the following:</p> <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR B. The the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related

Module	Clinical Criteria for Approval
	<p style="text-align: right;">to stage four advanced metastatic cancer AND</p> <ol style="list-style-type: none"> 2. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR <ol style="list-style-type: none"> B. The patient has ONE of the following: <ol style="list-style-type: none"> 1. Tried and had an inadequate response to ONE triptan or triptan combination agent OR 2. An intolerance or hypersensitivity to ONE triptan or triptan combination agent OR 3. An FDA labeled contraindication to ALL triptan and triptan combination agent(s) AND <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 ONE of the following: <ol style="list-style-type: none"> 1. The request is for a BCBS IL Fully Insured, ASO Cost/BBF, HIM, or Non-ERISA ASO/Self-insured Municipalities/Counties member OR 2. BOTH of the following: <ol style="list-style-type: none"> A. ONE of the following: <ol style="list-style-type: none"> 1. The patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR 2. The patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer AND B. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR 3. The patient is currently being treated with the requested agent and the patient is currently stable on the requested agent OR C. The patient has ONE of the following:

Module	Clinical Criteria for Approval
	<ol style="list-style-type: none"> 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 agent(s) for the requested indication OR <ol style="list-style-type: none"> D. ONE preferred agent was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event OR E. ONE preferred agent is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm OR F. ONE preferred agent is not in the best interest of the patient based on medical necessity OR G. The patient has tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE preferred agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event AND <ol style="list-style-type: none"> 4. The requested agent and strength is FDA labeled for the acute treatment of migraines OR <ol style="list-style-type: none"> C. The patient has another FDA labeled indication for the requested agent and route of administration AND <ol style="list-style-type: none"> 2. If the patient has an FDA labeled indication, then ONE of the following: <ol style="list-style-type: none"> 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 OR C. The patient has another indication that is supported in compendia for the requested agent and route of administration AND <ol style="list-style-type: none"> 2. The patient does NOT have any FDA labeled contraindications to the requested agent <p>Compendia Allowed: AHFS, or DrugDex 1, 2a, or 2b level of evidence</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>BCBSIL and BCBSMT: 12 months</p> <p>ALL other plans: Migraine prophylaxis - 6 months; all other indications - 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>

Module	Clinical Criteria for Approval
	<p>The requested agent will also be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The request is for a BCBS MT Fully Insured or MT HIM member AND <ol style="list-style-type: none"> A. The patient is under the age of 18 years old AND B. The patient does NOT have any FDA labeled contraindications to the requested agent AND C. The patient has an indication that is supported in TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] AND D. There is support for an age in the patient’s given age bracket in TWO articles from major peer-reviewed professional medical journals as generally safe and effective. The age brackets are: 1. infancy (birth up to, but not including, 2 years of age), 2. childhood (2 years of age through 11 years of age), 3. adolescence (12 years of age through 17 years of age). Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] OR 2. The request is for a BCBS NM Fully Insured or NM HIM member and ALL of the following: <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. The requested indication is a rare disease AND C. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. ALL of the following: <ol style="list-style-type: none"> A. The member resides in Ohio AND B. The plan is Fully Insured or HIM Shop (SG) AND C. The patient does NOT have any FDA labeled contraindications to the requested agent AND D. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p>

Module	Clinical Criteria for Approval
	<p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> A. The requested agent is being used for migraine prophylaxis AND ALL of the following: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 Ajoovy, then ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 or migraines AND ALL of the following: <ol style="list-style-type: none"> 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 <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p>

Module	Clinical Criteria for Approval
	NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity Limit for Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication OR B. BOTH of the following: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> A. The patient is currently being treated with a migraine prophylactic medication (i.e., anticonvulsants [i.e., divalproex, valproate, topiramate], beta blockers [i.e., atenolol, metoprolol, nadolol, propranolol, timolol], tricyclic antidepressants [i.e., amitriptyline, nortriptyline], SNRIs [i.e., venlafaxine, duloxetine], candesartan, prophylactic use CGRP [e.g., Aimovig, Ajovy, Emgality, Nurtec ODT, Qulipta, Vyepti], OR onabotulinumtoxin A [Botox]) OR B. The patient has an intolerance or hypersensitivity to therapy with migraine prophylactic medication (i.e., anticonvulsants [i.e., divalproex, valproate, topiramate], beta blockers [i.e., atenolol, metoprolol, nadolol, propranolol, timolol], tricyclic antidepressants [i.e., amitriptyline, nortriptyline], SNRIs [i.e., venlafaxine, duloxetine], candesartan, prophylactic use CGRP [e.g., Aimovig, Ajovy, Emgality, Nurtec ODT, Qulipta, Vyepti], onabotulinumtoxin A [Botox]) OR C. The patient has an FDA labeled contraindication to ALL migraine prophylactic medications (i.e., anticonvulsants [i.e., divalproex, valproate, topiramate], beta blockers [i.e., atenolol, metoprolol, nadolol, propranolol, timolol], tricyclic antidepressants [i.e., amitriptyline, nortriptyline], SNRIs [i.e., venlafaxine, duloxetine], candesartan, prophylactic use CGRP [e.g., Aimovig, Ajovy, Emgality, Nurtec ODT, Qulipta, Vyepti], AND onabotulinumtoxin A [Botox]) 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 <p>Length of Approval:</p> <p>BCBSIL: 12 months</p> <p>ALL other plans:</p>

Module	Clinical Criteria for Approval
	<p>Initial:</p> <p>For migraine prophylaxis: 6 months</p> <p>All other indications: 12 months</p> <p>Renewal: 12 months</p> <p>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.</p>