HARVARD PILGRIM HEALTH CARE
RECOMMENDED MEDICATION REQUEST GUIDELINES

ORAL ABORTIVE ANTIMIGRAINE AGENTS (TRIPTANS)

Generic	Brand	HICL	GCN	Exception/Other
ALMOTRIPTAN	AXERT	21894		ROUTE = ORAL
FROVATRIPTAN	FROVA	22988		ROUTE = ORAL
NARATRIPTAN	AMERGE	13266		ROUTE = ORAL
RIZATRIPTAN	MAXALT	18535		ROUTE = ORAL
RIZATRIPTAN ODT	MAXALT MLT	18535		ROUTE = ORAL
SUMATRIPTAN	IMITREX	06587		ROUTE = ORAL
SUMATRIPTAN/NAPROXEN	TREXIMET	35534		ROUTE = ORAL
ZOLMITRIPTAN	ZOMIG	12958		ROUTE = ORAL
ZOLMITRIPTAN ODT	ZOMIG ZMT	12958		ROUTE = ORAL
ELETRIPTAN HBR	RELPAX	23093		ROUTE = ORAL

NOTE: Prescriptions that meet the initial step therapy requirements will adjudicate at the point of service. If the member does not meet the initial step therapy criteria, then the prescription will deny at point of service with a message indicating that prior authorization (PA) is required.

Members who do not meet the step therapy criteria at point of service will need to submit a Medication Request Form (MRF) to MedImpact for clinical review. First level drug therapy required include the following:

- Generic almotriptan, generic eletriptan, generic naratriptan, generic rizatriptan, generic sumatriptan (any dosage form), generic zolmitriptan
- Lookback is 180 days,
- Lookback for itself or first-line agents.

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Is the request for Treximet?

   If yes, continue to #5.
   If no, continue to #2.

2. Is the request for a multisource brand?

   If yes, continue to #3.
   If no, continue to #4.

CONTINUED ON NEXT PAGE

ORAL ABORTIVE ANTIMIGRAINE AGENTS (TRIPTANS)

INITIAL CRITERIA (CONTINUED)

3. Has the patient tried and failed therapy with the generic product of the requested drug **AND** at least two additional triptan medications, e.g., Axert (almotriptan), Frova (frovatriptan), Amerge (naratriptan), Maxalt (rizatriptan), Imitrex (sumatriptan), generic eletriptan, Treximet (sumatriptan/naproxen), Zomig (zolmitriptan)?

   If yes, **approve for 12 months by GPID.** (The quantity limits are hard-coded as noted at the end of the guideline). Please use status code #056 and the approval text provided.
   Requests for products on formulary with a restriction.
   APPROVAL TEXT: Your request for **[DRUG]** has been approved with a quantity limit of _____ per copay for a 12-month period.

   Requests for products not on formulary.
   APPROVAL TEXT: Your request for **[DRUG]** has been approved for a 12-month period with a quantity limit of _____ per copay at your highest cost-share tier. Refer to your Harvard Pilgrim ID card for the amount you pay for drugs on that tier.

   If no, do not approve. Please use status code #238 and the denial text provided.
   DENIAL TEXT: Per your health plan's Oral Abortive Antimigraine Agents (Triptans) guideline, a trial of both the requested drug's generic equivalent **AND** at least two alternative triptan medications, such as eletriptan, naratriptan, rizatriptan, sumatriptan, or zolmitriptan used to treat your condition is required prior to approving coverage of the requested medication. Your provider did not indicate that you have tried **[the generic and at least two covered formulary alternatives]** and therefore your request was not approved.

4. Has the patient tried and failed therapy with at least two alternative triptan medications, e.g., generic almotriptan, generic eletriptan, generic naratriptan, generic rizatriptan, generic sumatriptan (any dosage form), or generic zolmitriptan?

   If yes, **approve for 24 months by GPID.** (The quantity limits are hard-coded as noted at the end of the guideline). Please use status code #056 and the approval text provided.
   Requests for products on formulary with a restriction:
   APPROVAL TEXT: Your request for **[DRUG]** has been approved with a quantity limit of _____ per copay for a 24-month period.

   Requests for products not on formulary:
   APPROVAL TEXT: Your request for **[DRUG]** has been approved for a 24-month period with a quantity limit of _____ per copay at your highest cost-share tier. Refer to your Harvard Pilgrim ID card for the amount you pay for drugs on that tier.

   If no, do not approve. Please use status code #238 and the denial text provided.
   DENIAL TEXT: Per your health plan's Oral Abortive Antimigraine Agents (Triptans) guideline, a trial with at least two alternative triptan medications, such as almotriptan, eletriptan, naratriptan, rizatriptan, sumatriptan, or zolmitriptan is required prior to approving coverage for the requested medication. Your provider did not indicate that you have tried two of these medications and therefore your request was not approved.

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ORAL ABORTIVE ANTIMIGRAINE AGENTS (TRIPTANS)

INITIAL CRITERIA (CONTINUED)

5. Has the patient tried and failed therapy with <u>at least three</u> triptans [e.g. generic eletriptan, generic almotriptan, generic naratriptan, generic rizatriptan, generic sumatriptan (any dosage form), or generic zolmitriptan] **one of which was in combination** with a Nonsteroidal Anti-Inflammatory Drug (NSAID), such as naproxen or ibuprofen?

   If yes, **approve Treximet for 12 months by GPID.** (The quantity is hard-coded for 9 tablets per copay). Please use status code #056 and the approval text provided.
   <u>Requests for products on formulary with a restriction</u>.
   APPROVAL TEXT: Your request for **Treximet** has been approved with a quantity limit of 9 tablets per copay for a 12-month period.

   <u>Requests for products not on formulary</u>.
   APPROVAL TEXT: Your request for **Treximet** has been approved for a 12-month period with a quantity limit of 9 tablets per copay at your highest cost-share tier. Refer to your Harvard Pilgrim ID card for the amount you pay for drugs on that tier.

   If no, do not approve. Please use status code #238 and the denial text provided.
   DENIAL TEXT: Per your health plan's Oral Abortive Antimigraine Agents (Triptans) guideline, a trial of at least three triptan medications, one of which was taken in combination with a Nonsteroidal Anti-Inflammatory Drug (NSAID), such as naproxen or ibuprofen, is required prior to approving coverage of Treximet. Triptan medications include almotriptan, eletriptan, naratriptan, rizatriptan, sumatriptan, and zolmitriptan. Your provider did not indicate that you have been treated with at least three of these medications, including one taken together with an NSAID, and therefore your request was not approved.

   QUANTITY LIMITS for brand name products and equivalent generics:
   - Amerge 1mg tablets: (The quantity is hard-coded for 15 tablets per copay)
   - Amerge 2.5mg tablets: (The quantity is hard-coded for 6 tablets per copay)
   - Axert 6.25mg tablets: (The quantity is hard-coded for 12 tablets per copay)
   - Axert 12.5mg tablets: (The quantity is hard-coded for 6 tablets per copay)
   - Frova 2.5mg tablets: (The quantity is hard-coded for 9 tablets per copay)
   - Imitrex 25mg tablets: (The quantity is hard-coded for 24 tablets per copay)
   - Imitrex 50mg tablets: (The quantity is hard-coded for 12 tablets per copay)
   - Imitrex 100mg tablets: (The quantity is hard-coded for 6 tablets per copay)
   - Maxalt/Maxalt MLT 5mg tablets: (The quantity is hard-coded for 18 tablets per copay)
   - Maxalt/Maxalt MLT 10mg tablets: (The quantity is hard-coded for 9 tablets per copay)
   - Relpax 20 mg tablets: (The quantity is hard-coded for 12 tablets per copay)
   - Relpax 40mg tablets: (The quantity is hard-coded for 6 tablets per copay)
   - Zomig/Zomig ZMT 2.5mg tablets:(The quantity is hard-coded for 12 tablets per copay)
   - Zomig/Zomig ZMT 5mg tablets: (The quantity is hard-coded for 6 tablets per copay)

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ORAL ABORTIVE ANTIMIGRAINE AGENTS (TRIPTANS)

GUIDELINES FOR USE (CONTINUED)

RENEWAL CRITERIA

1. Has the patient experienced improvement while on therapy?

   If yes, **approve for 24 months by GPID.** (The quantity limits are hard-coded as noted above.) Please use status code #056 and the approval text provided.
   Requests for products on formulary with a restriction.
   APPROVAL TEXT: Your request for **[DRUG]** has been approved with a quantity limit of _____ per copay for a 24-month period.

   Requests for products not on formulary.
   APPROVAL TEXT: Your request for **[DRUG]** has been approved for a 24-month period with a quantity limit of _____ per copay at your highest cost-share tier. Refer to your Harvard Pilgrim ID card for the amount you pay for drugs on that tier.

   If no, do not approve. Please use status code #238 and the denial text provided.
   DENIAL TEXT: Per your health plan's Oral Abortive Antimigraine Agents (Triptans) guideline, authorization for renewal requires documentation of improvement of symptoms while on therapy. Your provider did not indicate that your symptoms have improved with **[DRUG]** therapy and therefore your request was not approved.

RATIONALE
To promote first line use of preferred abortive antimigraine agents.

FDA APPROVED INDICATIONS
Treatment of migraine headache with or without aura (all triptans).

REFERENCES

- Amerge tablets package insert. GlaxoSmithKline. Research Triangle Park, NC. February 2010.
- Axert tablets package insert. Ortho-McNeil. Titusville, NJ. April 2009.
- Frova tablets package insert. Endo Pharmaceuticals. Chadds Ford, PA. April 2007.
- Imitrex tablets package insert. GlaxoSmithKline. Research Triangle Park, NC. February 2010.
- Maxalt tablets and Maxalt-MLT orally disintegrating tablets package insert. Merck & Co. Whitehouse Station, NJ. December 2009.
- Relpax tablets package insert. Pfizer Roerig. New York, NY. May 2008.
- Treximet package insert. GlaxoSmithKline. Research Triangle Park, NC. December 2009.
- Zomig tablets and Zomig ZMT orally disintegrating tablets package insert. AstraZeneca Pharmaceuticals. Wilmington, DE, October 2008.

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