Drug Therapy Guidelines

Calcitonin Gene-Related Peptide (CGRP) Antagonists – Preventive Treatment: Aimovig™ (erenumab-aooe), Ajovy™ (fremanezumab-vfrm), Emgality™ (galcanezumab-gnlm), Vyepti™ (eptinezumab-jjmr)

| Medical Benefit | x | Effective: 5/1/20 |
| Pharmacy- Formulary 1 | x | Next Review: 9/20 |
| Pharmacy- Formulary 2 | x | Date of Origin: 6/18 |
| Pharmacy- Formulary 3/Exclusive | x | Review Dates: 6/18, 9/18, 12/18, 9/19, 12/19, 3/20 |
| Pharmacy- Formulary 4/AON | x |

I. Medication Description

Calcitonin gene-related peptide (CGRP) is distributed throughout the nervous system, and it is concentrated at anatomical sites, such as the trigeminovascular system, which are involved in migraine pathophysiology. Centrally, CGRP is involved in nociceptive transmission through second and third order neurons and pain modulation in the brainstem. Peripherally, CGRP mediates vasodilation through smooth muscle receptors. CGRP concentrations are elevated during acute migraine attacks and may be chronically elevated in chronic migraineurs.

CGRP antagonists are monoclonal antibodies that have high affinity for binding to the calcitonin gene-related peptide (CGRP) receptor antagonizing the CGRP receptor function.

Currently, there are four FDA-approved CGRP antagonists indicated for the preventive treatment of migraines: Aimovig, Ajovy, Emgality, and Vyepti.

II. Position Statement

Coverage is determined through a prior authorization process for all requests.

- Ajovy will be available under the medical and pharmacy benefits.
- Aimovig and Emgality will be available under the pharmacy benefit.
- Vyepti will be available under the medical benefit.

III. Policy

Coverage of Aimovig, Ajovy, Emgality, or Vyepti is provided for the following conditions when the listed criteria are met (only one CGRP antagonist may be approved at a time):

- Prevention of Chronic Migraine:
  - Member is at least 18 years of age AND
  - Member has a documented diagnosis of chronic migraines (defined as at least 15 headache days per month with headache lasting at least 4 hours per day) AND
  - Through a prior authorization (attestation from the provider will suffice if all information is provided), member-specific information has been provided to include ALL of the following:
    - Headache frequency and duration (number of headache and migraine days per month, number of headache hours per day)
    - Reported severity (e.g. pain scale)
    - Treatment history (list of all medications member has previously attempted for this diagnosis, with treatment results) AND
  - At least ONE of the following is true:
    - Member has been unable to tolerate or has had an inadequate response to minimum of TWO 6-week trials with different types of specific prophylactic medications with
sufficient evidence to support use in migraines (for example: antiepileptics, antidepressants, antihypertensives) OR

- Member has been unable to tolerate or has had inadequate response to minimum of two quarterly injections (6 months) of botulinum toxin for the treatment of chronic migraine AND
  - Member is not concurrently receiving botulinum toxin for the treatment of migraines.

- Prevention of Episodic Migraine:
  - Member is at least 18 years of age AND
  - Member has a documented diagnosis of episodic migraines (defined as 4-14 headache days per month) AND
  - Through a prior authorization (attestation from the provider will suffice if all information is provided), member-specific information has been provided to include ALL of the following:
    - Headache frequency and duration (number of headache and migraine days per month, number of headache hours per day)
    - Reported severity (e.g. pain scale)
    - Treatment history (list of all medications member has previously attempted for this diagnosis, with treatment results) AND
  - Member has been unable to tolerate or has had an inadequate response to minimum of TWO 6-week trials with different types of specific prophylactic medications with sufficient evidence to support use in migraines (for example: antiepileptics, antidepressants, antihypertensives).

AND

- For coverage under the pharmacy benefit only:
  - When requesting coverage of a brand medication for which a plan-preferred A/B rated generic is available, coverage will be provided when there is sufficient evidence that the use of the A/B rated generic equivalent has resulted in inadequate results AND
  - Coverage of the non-preferred medication (Emgality) can be considered if the member has first attempted therapy with ONE plan-preferred medication (Aimovig or Ajovy) OR when at least ONE of the following criteria have been met:
    - The plan-preferred medications are contraindicated or will likely cause an adverse reaction by or physical or mental harm to the member.
    - The plan-preferred medications are expected to be ineffective based on the known clinical history and conditions of the member and the member’s prescription drug regimen.
    - The member has tried the plan-preferred medications or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
    - The member is stable on the medication selected by their healthcare professional for the medical condition under consideration (where “stable” is defined as receiving the medication for an adequate period of time, have achieved optimal response, and continued favorable outcomes are expected UNLESS the medication was initially selected due to the availability of a drug sample or a coupon card and the member does not otherwise meet the definition of “stable”).
    - The plan-preferred medication is not in the best interest of the member because it will likely cause a significant barrier to the member’s adherence or to compliance with the
member’s plan of care, will likely worsen a comorbid condition of the member, or will likely decrease the member’s ability to achieve or maintain reasonable functional ability in performing daily activities.

Coverage of Emgality is provided for the following condition when the listed criteria are met:

- Treatment of Episodic Cluster Headaches:
  - Member is at least 18 years of age AND
  - Member meets the International Classification of Headache Disorders 3rd edition (beta version) diagnostic criteria for episodic cluster headache AND
  - Member-specific information has been provided to include ALL of the following:
    - Headache frequency and duration (incidence and duration of cluster periods, number of attacks per day during cluster periods)
    - Duration of pain free periods
    - Reported severity (e.g. pain scale)
    - Treatment history (list of all medications member has previously attempted for this diagnosis, with treatment results).

IV. Quantity Limitations

Coverage is available as follows:

- Aimovig: One 70 mg or 140 mg injection per 30 days
- Ajovy: One 225 mg/1.5 injection per 30 days or up to 3 injections per 90 days
- Emgality:
  - For the preventive treatment of migraine:
    - Two injections (total of 240 mg) for the first 30 days, then 1 injection (120 mg) per 30 days thereafter
  - For the treatment of episodic cluster headache:
    - Three 100 mg injections (total of 300 mg) per 30 days for the duration of the cluster period
- Vyepti:
  - Initial coverage:
    - One 100 mg infusion per 90 days
  - Coverage of 300 mg dose:
    - If documentation is available confirming that a trial with 100 mg dose did not result in acceptable migraine symptom control, coverage of 300 mg per 90 days will be approved

V. Coverage Duration

- Aimovig and Ajovy:
  - Initial coverage is available for 3 months and may be renewed.
- Emgality:
  - For the prevention of migraine:
    - Initial coverage is available as follows and may be renewed:
      - Prevention of episodic migraines: 6 months
      - Prevention of chronic migraines: 3 months
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O For the treatment of episodic cluster headache
  ▪ Initial coverage is available for 1 month.

Vyepti:
  ▪ Initial coverage is available for 3 months and may be renewed.

VI. Coverage Renewal Criteria

Coverage can be renewed as follows:

• For the prevention of migraine:
  ▪ Coverage of Aimovig, Ajovy, Emgality, or Vyepti may be renewed in 12 month intervals based upon the following criteria:
    ▪ Decrease in the migraine frequency compared to that at baseline (pre-treatment) AND
    ▪ Absence of unacceptable toxicity from the drug.

• For the treatment of episodic cluster headache:
  ▪ Coverage of Emgality may be renewed on a case-by-case basis depending on the duration of the cluster period.

VII. Billing/Coding Information

Available as:

• Aimovig:
  ▪ Available through the pharmacy benefit
  ▪ SureClick® Autoinjector
    ▪ Pack of 1 autoinjector: 70 mg/mL single-dose prefilled autoinjector
    ▪ Pack of 1 autoinjector: 140mg/mL single-dose prefilled autoinjector

• Ajovy:
  ▪ Available through the medical benefit and pharmacy benefit
  ▪ 225 mg/1.5 mL solution in a single-dose prefilled syringe (pack of 1)
  ▪ 225 mg/1.5 ml solution in a single-dose prefilled autoinjector (pack of 1)
  ▪ J3031: 1 billable unit = 1mg

• Emgality:
  ▪ Available through the pharmacy benefit
  ▪ 120 mg/mL solution in a single-dose prefilled pen (carton of 1 or 2)
  ▪ 120 mg/mL solution in a single-dose prefilled syringe (carton of 1 or 2)
  ▪ 100 mg/mL solution in a single-dose prefilled syringe (carton of 3)

• Vyepti:
  ▪ Available through the medical benefit
  ▪ 100 mg/ml in a single-dose vial for injection that requires dilution prior to administration.

VIII. Summary of Policy Changes

• 8/15/18: new policy
• 11/1/18: no policy changes
• 2/15/19: policy name changed from “Aimovig” to “Calcitonin Gene-Related Peptide (CGRP) Antagonists”; addition of Ajovy and Emgality to the policy
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- 4/26/19: updated billing/coding and quantity limitations
- 5/15/19: removed specialist prescriber for chronic migraines; added step therapy with Ajovy; updated billing/coding information
- 10/23/19: policy updated to reflect preferred products for the preventive treatment of migraines: Aimovig and Ajovy
- 11/15/19: added criteria for treatment of episodic cluster headache as a new indication for Emgality; updated quantity limits, duration of coverage/renewal criteria, and billing/coding information
- 1/30/20: updated criteria regarding requested trials of medications for the treatment of chronic migraine
- 5/1/20: added Vyepti to policy (medical benefit); updated billing/coding information

IX. References

14. Ajovy™ injection for subcutaneous use [prescribing information]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; September 2018


25. Clinical Pharmacology Online, retrieved 12/2018


30. Emgality™ injection for subcutaneous use [prescribing information]. Indianapolis, IN: Eli Lilly and Company; 6/2019
| Drug Therapy Guidelines | Calcitonin Gene-Related Peptide (CGRP) Antagonists – Preventive Treatment: Aimovig™ (erenumab-aooe), Ajovy™ (fremanezumab-vfrm), Emgality™ (galcanezumab-gnlm), Vyepti™ (eptinezumab-jjmr) | Last Review Date: 3/2020 |

34. Vyepti [prescribing information]. Bothell, WA. Lundbeck Seattle Biopharmaceuticals, Inc. Revised 2/2020

*These guidelines are not applicable to benefits covered under Medicare Advantage. Medicare Advantage benefit coverage requests are reviewed in accordance with the guidance set forth in Chapter 15 Section 50 of the Centers for Medicare & Medicaid Services Medicare Benefit Policy Manual.

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary medication will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.