Louisiana Medicaid
Pain Management – Antimigraine Agents – Calcitonin Gene-Related Peptide (CGRP) Antagonists

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for calcitonin gene-related peptide (CGRP) antagonists.

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy for Erenumab-aooe (Aimovig®), Fremanezumab-vfrm (Ajovy®) or Galcanezumab-gnlm (Emgality®)

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has been evaluated and does not have medication overuse headache, and this is **stated on the request**; **AND**
- The prescriber **states on the request** that the requested medication is being used for preventative treatment of migraines; **AND**
- The prescriber **states on the request** that the requested medication is not prescribed concurrently with other CGRP inhibitors being used for prevention of migraines; **AND**
- The dosage and administration follow prescribing information for the diagnosis being treated; **AND**
- The following is true and **stated on the request**:
    - The recipient has a diagnosis of migraine; **AND**
    - The recipient has a history of migraines for at least 3 months; **AND**
    - The recipient failed treatment with an adequate trial (3 months each) of at least **TWO** standard prophylactic pharmacologic therapies for migraine, or has an intolerance or contraindication to standard prophylactic therapies (e.g., beta blockers, antidepressants, divalproex sodium or topiramate); **OR**
- For galcanezumab-gnlm (Emgality®), **the following is true and is stated on the request**:
    - The recipient has a diagnosis based on documented history of episodic cluster headaches; **AND**
    - The recipient is in an active cluster period; **AND**
    - The recipient has failed treatment with **AT LEAST ONE** triptan indicated for the treatment of cluster headaches (unless contraindicated); **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has a *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated**.**

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The following **is true and stated on the request**:
  - The recipient continues to be monitored for medication overuse headache; **AND**
  - There is evidence of a positive clinical response to CGRP antagonist therapy.

Duration of approval for ~~initiation and~~ continuation of therapy: 12 months

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Atogepant (Qulipta™)

Approval Criteria for Initiation of Therapy

- The recipient is 18 years of age or older on the date of the request; **AND**
- The prescriber **states on the request** that the requested medication is being used for preventative treatment of migraines; **AND**
- The prescriber **states on the request** that the requested medication is not prescribed concurrently with other CGRP inhibitors being used for prevention of migraines; **AND**
- The following is true and **stated on the request**:
  - The recipient has a diagnosis of migraine; **AND**
  - The recipient has a history of migraines for at least 3 months; **AND**
  - The recipient failed treatment with an adequate trial (3 months each) of at least **TWO** standard prophylactic pharmacologic therapies for migraine, or has an intolerance or contraindication to standard prophylactic therapies (e.g., beta blockers, antidepressants, divalproex sodium or topiramate); **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has a *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated**.**

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for continuation of therapy: 12 months

Eptinezumab-jjmr (Vyepti™)

Approval Criteria for Initiation of Therapy

- The recipient is 18 years of age or older on the date of the request; **AND**

- The prescriber **states on the request** that the requested medication is being used for preventative treatment of migraines; **AND**
- The prescriber **states on the request** that the requested medication is not prescribed concurrently with other CGRP inhibitors being used for prevention of migraines; **AND**
- For eptinezumab-jjmr (Vyepti™), the following is true and is **stated on the request**:
    - The recipient has a diagnosis of migraine; **AND**
    - The recipient has a history of migraines for at least 3 months; **AND**
    - The recipient failed treatment with an adequate trial (3 months each) of at least **TWO** standard prophylactic pharmacologic therapies for migraine, or has an intolerance or contraindication to standard prophylactic therapies (e.g., beta blockers, antidepressants, divalproex sodium or topiramate); **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has a *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated**.**

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established with evidence of a positive clinical response.

Duration of approval for ~~initiation and~~ continuation of therapy: 12 months

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Rimegepant (Nurtec® ODT)

Approval Criteria for Initiation of Therapy

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of migraine, with or without aura; **AND**
- The prescriber **states on the request** whether the requested medication is being used for migraine prevention or for acute migraine treatment; **AND**
- The prescriber **states on the request** that the requested medication is not prescribed concurrently with other CGRP inhibitors; **AND**
- **ONE** of the following is true (names of medications and trial dates must be **stated on the request**):
    - If the requested medication is being used to treat moderate to severe pain associated with acute migraine, then the recipient has had a trial of and inadequate response, intolerance or contraindication to **TWO** triptans (at least one must be preferred); **OR**
    - If the requested medication is being used as preventive treatment of episodic migraines, then the recipient had treatment failure of or intolerance to a preferred injectable

calcitonin gene-related peptide (CGRP) monoclonal antibody (e.g., Ajovy®, Emgality®); **AND**

- If the request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has a *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated**.**

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for continuation of therapy: 12 months

Ubrogepant (Ubrelvy®)

Approval Criteria for Initiation of Therapy

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of migraine, with or without aura; **AND**
- The requested medication is being used to treat moderate to severe pain associated with acute migraine, which is **stated on the request**; **AND**
- The prescriber **states on the request** that the requested medication is not prescribed concurrently with other CGRP inhibitors being used for acute treatment of migraines; **AND**
- The recipient has had a trial of and inadequate response, intolerance or contraindication to **TWO** oral triptans (at least one must be preferred; names of triptans and trial dates must be **stated on the request**); **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has a *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated**.**

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for continuation of therapy: 12 months

Zavegepant (Zavzpret™)

Approval Criteria for Initiation of Therapy

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of migraine, with or without aura; **AND**
- The requested medication is being used to treat moderate to severe pain associated with acute migraine, which is **stated on the request**; **AND**
- The prescriber **states on the request** that the requested medication is not prescribed concurrently with other CGRP inhibitors being used for acute treatment of migraines; **AND**
- The recipient has had a trial of and inadequate response, intolerance or contraindication to **TWO** oral triptans (at least one must be preferred; names of triptans and trial dates must be **stated on the request**); **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has a *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated**.**

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for continuation of therapy: 12 months

References

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Revision / Date	**Implementation Date**
Added wording for new indication, strength and quantity limit for Emgality® / July 2019	November 2019
Removed POS information, formatting changes, updated references / July 2020	July 2020
Added Nurtec™ ODT, Ubrelvy® and Vyepti® / July 2020	August 2020
Updated references, formatting changes / May 2021	July 2021
Updated indication for Nurtec® ODT, removed prescriber specialty, updated references, formatting changes / June 2021	January 2022
Combined Qulipta™ with current criteria, updated references / May 2022	July 2022
Modified previous use criteria for Nurtec® ODT, updated references / November 2022	April 2023
Modified Qulipta™ criteria to allow for expanded indication, simplified migraine diagnosis in selected agents, updated references / May 2023	October 2023
Combined Zavzpret™ with current criteria / October 2023	January 2024

Clarified the criteria pertaining to the prior use of triptans, formatting changes / July 2024	October 2024
Added criteria to prevent duplicate CGRP therapy for same indication, applied 6 month initial approval duration consistently throughout document / March 2025	August 2025