PRIOR AUTHORIZATION POLICY

POLICY: Migraine – Calcitonin Gene-Related Peptide Inhibitors – Emgality Prior Authorization Policy
- Emgality® (galcanezumab-gnlm subcutaneous injection – Lilly)

REVIEW DATE: 04/16/2025; selected revision 05/28/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Emgality, a calcitonin gene-related peptide (CGRP) antagonist, is indicated in adults for the following uses:[1]
- **Episodic cluster headache treatment**.
- **Migraine headache prevention**.

Disease Overview

Migraines have been defined as chronic or episodic. Chronic migraine is described by the International Headache Society as headache occurring on ≥ 15 days/month for > 3 months and has the features of migraine headache on ≥ 8 days/month.[2] Episodic migraine is characterized by headaches that occur < 15 days/month.[3] Episodic migraine is more common than chronic migraine; however, chronic migraine is associated with a markedly greater personal and societal burden.

Cluster headaches are associated with attacks of severe, strictly unilateral pain which is orbital, supraorbital, temporal, or in any combination of these sites, lasting 15 to 180 minutes.[2] The headaches occur from once every other day to eight times a day. Cluster headache is considered among the most severe of the primary headache disorders because of extreme pain, associated autonomic symptoms, and high attack frequency.[5] In addition, a large proportion of patients with cluster headache have chronic cluster headache, which features only brief or no remission periods, and may be particularly refractory to medical therapies.

Guidelines

An updated assessment of the **preventive and acute treatment of migraine** by the **American Headache Society** (AHS) [2018; update 2021] reaffirms previous migraine guidelines.[6,7] Patients with migraine should be considered for preventive treatment in the following situations: when attacks significantly interfere with patients' daily routines despite acute treatment; frequent attacks (≥ 4 monthly headache days); at least moderate disability (Migraine Disability Assessment [MIDAS] score ≥ 11 or six-item Headache Impact Test [HIT-6] score > 50); contraindication to, failure, overuse, or adverse events with acute treatments; or patient preference. Before developing a preventive treatment plan, the appropriate use (e.g., drug type, route and timing of administration, frequency) of acute treatments should be initiated and coupled with education and lifestyle modifications. All patients with migraine should be offered a trial of acute treatment. Based on the level of evidence for efficacy and the American Academy of Neurology scheme for classification of evidence, the following oral treatments have established efficacy and should be offered for migraine prevention: antiepileptic drugs (**divalproex sodium, valproate sodium, topiramate** [not for women of childbearing potential without a reliable method of birth control]); beta-blockers (**metoprolol, propranolol, timolol**); and **frovatriptan** (for short-term preventive treatment of menstrual migraine). The following treatments are probably effective and should be considered for migraine prevention: antidepressants (**amitriptyline, venlafaxine**); beta-blockers (**atenolol, nadolol**); and angiotensin receptor blockers (**candesartan**).

The **AHS** issued an update to their position statement (2024) specifically regarding therapies targeting CGRP for the prevention of migraine.[8] The evidence for the efficacy, tolerability, and safety of CGRP-targeting migraine preventive therapies (specifically, the monoclonal antibodies: Aimovig [erenumab-aooe subcutaneous {SC} injection], Ajovy® [fremanezumab-vfrm SC injection], Emgality® [galcanezumab-gnlm SC injection], and Vyepti® [eptinezumab-jjmr intravenous infusion], and the gepants: Nurtec® ODT [rimegepant orally disintegrating tablets] and Qulipta® [atogepant tablets]) is substantial and consistent across different individual CGRP-targeting treatments. Extensive "real-world" clinical experience corroborates clinical trials. This data indicates that the efficacy and tolerability of CGRP-targeting therapies are equal to or greater than those of previous first-line therapies. The CGRP-targeting therapies should be considered as a first-line approach for migraine prevention along with previous first-line treatments without a requirement for prior failure of other classes of migraine preventive treatment. Additionally, Botox® (onabotulinumtoxinA SC injection) is considered a first-line therapy for prevention of chronic migraine.

The **AHS** has published evidence-based guidelines on the **treatment of cluster headache** (2016).[5] The guidelines recommend sumatriptan subcutaneous, zolmitriptan nasal spray, and high flow oxygen for acute treatment. For prophylactic therapy, suboccipital steroid injection has been established as effective for the prophylactic therapy of episodic and chronic cluster headache (Level A). Lithium, verapamil, and melatonin are considered possibly effective for the prophylactic therapy of episodic and chronic cluster headache (Level C). Currently, there is insufficient evidence to make a recommendation for frovatriptan and prednisone (Level U).

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Emgality. All approvals are provided for the duration noted below.

- **Emgality® (galcanezumab-gnlm subcutaneous injection – Lilly)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

1. **Episodic Cluster Headache Treatment.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has between one headache every other day and eight headaches per day; AND
   - **C)** Patient has tried at least one standard prophylactic (preventive) pharmacologic therapy for cluster headache; AND
     Note: Examples of standard prophylactic (preventive) pharmacologic therapies for cluster headache include lithium, verapamil, melatonin, frovatriptan, prednisone, suboccipital steroid injection, topiramate, and valproate.
   - **D)** According to the prescriber, patient has had inadequate efficacy or has experienced adverse event(s) severe enough to warrant discontinuation of the standard prophylactic (preventive) pharmacologic therapy.

2. **Migraine Headache Prevention.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has ≥ 4 migraine headache days per month (prior to initiating a migraine-preventive medication); AND
   C) If the patient is currently taking Emgality, the patient has had a significant clinical benefit from the medication, as determined by the prescriber.
   Note: Examples of significant clinical benefit include a reduction in the overall number of migraine days per month or a reduction in number of severe migraine days per month from the time that Emgality was initiated.

CONDITIONS NOT COVERED

- **Emgality® (galcanezumab-gnlm subcutaneous injection – Lilly)**

is(are) considered not medically necessary for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Acute Treatment of Migraine.** Emgality has not been studied for the acute treatment of migraine.

2. **Concurrent use with another calcitonin gene-related peptide (CGRP) inhibitor being prescribed for migraine headache prevention.**
   Note: CGRP inhibitors that are indicated for migraine headache prevention include Aimovig (erenumab-aooe subcutaneous injection), Ajovy (fremanezumab-vfrm subcutaneous injection), Vyepti (eptinezumab-jjmr intravenous infusion), and Qulipta (atogepant tablets). Ajovy, Aimovig, Emgality, and Vyepti are injectable CGRP inhibitors for migraine prevention and have not been studied for use in combination with another agent in the same class.[9-11] Qulipta is an oral CGRP inhibitor for the preventive treatment of migraine in adults.[12]

3. **Concurrent use with Nurtec ODT (rimegepant sulfate orally disintegrating tablet) when used as a preventive treatment of migraine.** Nurtec ODT is an oral CGRP inhibitor for the acute treatment of migraine and for the preventive treatment of episodic migraine in adults.[13]

REFERENCES

1. Emgality® injection for subcutaneous use [prescribing information]. Indianapolis, IN: Lilly; March 2025.
2. Headache Classification Subcommittee of the International Headache Society. The International Classification of Headache Disorders: 3rd edition. *Cephalalgia*. 2018;38:1-211.
3. Damen JAA, Yang B, Idema DL, et al. Comparative effectiveness of pharmacologic treatments for the prevention of episodic migraine headache: A systematic review and network meta-analysis for the American College of Physicians. *Ann Intern Med*. 2025;178(3):369-380.
4. Burch R. Chronic migraine in adults. *JAMA*. 2025;333(5):423-424.

5. Robbins MS, Starling AJ, Pringsheim TM, et al. Treatment of cluster headache: the American Headache Society evidence-based guidelines. *Headache*. 2016;56:1093-1106.
6. American Headache Society. The American Headache Society position statement on integrating new migraine treatments into clinical practice. *Headache*. 2019;59:1-18.
7. Ailani J, Burch RC, Robbins MS, on behalf of the Board of Directors of the American Headache Society. The American Headache Society Consensus Statement: Update on integrating new migraine treatments into clinical practice. *Headache*. 2021;00:1–19.
8. Charles AC, Digre KB, Goadsby PJ, et al; American Headache Society. Calcitonin gene-related peptide-targeting therapies are a first-line option for the prevention of migraine: An American Headache Society position statement update. *Headache*. 2024;64(4):333-341.
9. Aimovig® subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; March 2025.
10. Ajovy® subcutaneous injection [prescribing information]. North Wales, PA: Teva; March 2025.
11. Vyepti® intravenous infusion [prescribing information]. Bothell, WA: Lundbeck; March 2025.
12. Qulipta® tablets [prescribing information]. Madison, NJ: AbbVie; March 2025.
13. Nurtec® ODT [prescribing information]. New York, NY: Pfizer; March 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Policy Name:** The initial descriptor "Migraine" was added to the policy name. **Migraine Headache Prevention:** The note with examples of standard prophylactic (preventive) pharmacologic therapies was expanded to include the statement: Of note, "standard prophylactic (preventive) pharmacologic therapies" do **not** include oral or injectable CGRP inhibitors.	05/24/2023
Selected Revision	**Migraine Headache Prevention:** • The note with standard prophylactic (preventive) pharmacologic therapies was changed to remove "Examples of" and to remove the statement: Of note, "standard prophylactic (preventive) pharmacologic therapies" do **not** include oral or injectable CGRP inhibitors. • A new statement was added: A patient who has already tried an oral or injectable calcitonin gene-related peptide (CGRP) inhibitor indicated for the prevention of migraine or Botox (onabotulinumtoxinA injection) for the prevention of migraine is not required to try two standard prophylactic pharmacologic therapies.	08/02/2023
Early Annual Revision	**Migraine Headache Prevention:** The criteria requiring a patient to have tried at least two standard prophylactic (preventive) pharmacologic therapies, each from a different pharmacologic class, and requiring that a patient has had inadequate efficacy or adverse event(s) severe enough to warrant discontinuation of those therapies have been removed.	04/10/2024
Annual Revision	No criteria changes.	04/16/2025
Selected Revision	**Episodic Cluster Headache Treatment:** Approval duration was changed from 6 months to 1 year.	05/28/2025