**Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache**

\*\*Emgality is also in 1a- CNS Agents: Anti-Migraine Agents, Prophylaxis

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| Criteria 1 | Emgality (NP proph/cluster HA) |

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| **Criteria Title** | Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis and Cluster Headache | | |
| **Criteria Subtitle** | Emgality | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| EMGALITY | 079818 | GCNSeqNo |
| EMGALITY | 078996 | GCNSeqNo |
| EMGALITY | 078997 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1999 |  | Select | What is the patient’s diagnosis? | Migraine Prophylaxis | 2000 |
| Cluster Headache | 3000 |
| Other | 1235 |
| 2 | 2000 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 2001 |
| Continuation (re-authorization request) | 1231 |
| 3 | 2001 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 2002 |
| N | 1235 |
| 4 | 2002 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least three preferred controller migraine drugs **AND** one step therapy drug?  Please note: Controller migraine drug classes include- beta-blockers, anticonvulsants, tricyclic antidepressants, or serotonin-norepinephrine reuptake inhibitors.  If yes, please submit the medication trials and dates. | Y | 2004 |
| N | 2003 |
| 5 | 2003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 2004 |
| N | 1236 |
| 6 | 2004 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 2005 |
| N | 2006 |
| 7 | 2005 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e., medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 2006 |
| N | 1235 |
| 8 | 2006 |  | Select | Ohio Medicaid covers up to 2 doses per 30 days (for initial loading dose only), then 1 dose per 30 days thereafter. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 9 | 3000 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request | 3001 |
| Continuation (re-authorization request) | 1232 |
| 10 | 3001 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 3002 |
| N | 1235 |
| 11 | 3002 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 60 days to at least one preferred drug?  If yes, please submit the medication trials and dates. | Y | 3004 |
| N | 3003 |
| 12 | 3003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 3004 |
| N | 1236 |
| 13 | 3004 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 3005 |
| N | 3006 |
| 14 | 3005 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e., medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 3006 |
| N | 1235 |
| 15 | 3006 |  | Select | Ohio Medicaid covers up to 3 doses (3 x 100mg) per 30 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 16 | 1231 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment (preferably a headache diary or other objective documentation of severity, frequency, and number of headache days per month)? | Y | 1233 |
| N | 1235 |
| 17 | 1232 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1234 |
| N | 1235 |
| 18 | 1233 |  | Select | Ohio Medicaid covers up to 1 dose per 30 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 19 | 1234 |  | Select | Ohio Medicaid covers up to 3 doses (3 x 100mg) per 30 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 20 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 21 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |
| 22 | 1237 |  | Free Text | Please provide the rationale for the dose and frequency being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS:

Prophylaxis: Initial Authorization 180 days; Subsequent Authorizations 365 days

Cluster: 180 days

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| **Last Approved** | 5/26/2023 |
| **Other** |  |