Clinical Policy: Migraine Products – Monoclonal Antibodies (Aimovig, Ajovy, Emgality, Vyepti)

Reference Number: AZ.CP.PHAR.1010
Effective Date: 10.01.19
Last Review Date: 02.21
Line of Business: Arizona Medicaid (AzCH-CCP and Care1st) Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Erenumab-aaoe (Aimovig™), Fremanezumab-vfrm (Ajovy™), Galcanezumab-gnlm (Emgality™), Eptinezumab-jjmr (Vyepti™) are calcitonin gene-related peptide (CGRP) receptor antagonists.

AHCCCS preferred drugs in this class include Fremanezumab-vfrm (Ajovy™) and Galcanezumab-gnlm (Emgality™).

AHCCCS non-preferred drugs in this class include Erenumab-aaoe (Aimovig™) and Eptinezumab-jjmr (Vyepti™).

FDA Approved Indication(s)

Aimovig, Ajovy and Vypeti are indicated for the preventive treatment of migraine in adults.

Emgality is indicated in adults for the:
• Preventive treatment of migraine
• Treatment of episodic cluster headache

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Arizona Complete Health-Complete Care Plan and Care1st that Aimovig, Ajovy, Emgality and Vyepti are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Migraine Prophylaxis (must meet all)**:**

1. Diagnosis of episodic or chronic migraine;
2. Request is for one of the following (a or b):
   a. Ajovy or Emgality;
   b. Aimovig or Vyepti: history of failure of both Ajovy and Emgality unless contraindicated or clinically significant adverse effects are experienced;
3. Member experiences ≥ 4 migraine days per month for at least 3 months;
4. Prescribed by or in consultation with a neurologist, headache, or pain specialist;
5. Age ≥ 18 years;

6. Failure of at least 2 of the following oral migraine preventative therapies, each for 8 weeks and from different therapeutic classes, unless contraindicated or clinically significant adverse effects are experienced: antiepileptic drugs (e.g., divalproex sodium, sodium valproate, topiramate), beta-blockers (e.g., metoprolol, propranolol, timolol), antidepressants (e.g., amitriptyline, venlafaxine);
7. Member is not prescribed concurrently with Botox® or other injectable CGRP inhibitors (e.g., Aimovig, Ajovy, Emgality, Vyepti);
8. For Aimovig, dose does not exceed one of the following (a or b):
   a. 70 mg (1 injection) once monthly;
   b. 140 mg (1 injection) once monthly if medical justification is provided.
9. For Emgality, dose does not exceed:
   a. Loading dose: 240 mg (2 injections) once;
   b. Maintenance dose: 120 mg (1 injection) once monthly.
10. For Ajovy, dose does not exceed one of the following (a or b):
    a. 225 mg (1 injection) once monthly;
    b. 675 mg (3 injections) every 3 months.
11. For Vyepti, dose does not exceed 100 mg (1 vial) once every 3 months.

Approval duration: 3 months

B. Episodic Cluster Headaches (must meet all):

1. Diagnosis of episodic cluster headaches as evidenced by both of the following (a and b):
   a. ≥ 1 cluster headache attack every other day and ≤ 8 cluster headache attacks per day with a total of ≥ 5 previous attacks;
   b. ≥ 2 cluster periods lasting ≤ 1 year each and separated by ≥ 3 months;
2. Request is for Emgality;
3. Prescribed by or in consultation with a neurologist, headache, or pain specialist;
4. Age ≥ 18 years;
5. Failure of verapamil at a dose of 360 mg per day, unless contraindicated or clinically significant adverse effects are experienced;
6. Emgality is not prescribed concurrently with Botox® or other injectable CGRP inhibitors (e.g., Aimovig, Ajovy, Emgality, Vyepti);
7. For Emgality, dose does not exceed 300 mg (3 injections) once monthly.

Approval duration: 3 months

C. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AZ.CP.PMN.53 for Arizona Medicaid.

II. Continued Therapy

A. Migraine Prophylaxis (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Request is for continuation of Ajovy, Emgality, Aimovig, or Vyepti.
3. Member is not prescribed concurrently with Botox or other injectable CGRP inhibitors (e.g., Aimovig, Ajovy, Emgality, Vyepti);
4. Member is responding positively to therapy as evidenced by a reduction in migraine days per month from baseline;
5. For Aimovig, if request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. 70 mg (1 injection) once monthly;
   b. 140 mg (1 injection) once monthly if medical justification is provided.
6. For Emgality, if request is for a dose increase, new dose does not exceed 120 mg (1 injection) once monthly.
7. For Ajovy, if request is for a dose increase, dose does not exceed one of the following (a or b):
   a. 225 mg (1 injection) once monthly;
   b. 675 mg (3 injections) every 3 months.
8. For Vyepti, if request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. 100 mg (1 vial) once every 3 months;
   b. 300 mg (3 vials) once every 3 months if medical justification for higher dose is provided.

Approval duration: 6 months

B. Episodic Cluster Headaches (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Request is for Emgality;
3. Member is responding positively to therapy as evidenced by a reduction in cluster headache attack frequency;
4. Member meets one of the following (a or b):
   a. Member has not received more than 12 months of consecutive treatment;
   b. It has been at least 3 months since the member last received Emgality;
5. Emgality is not prescribed concurrently with Botox or other injectable CGRP inhibitors (e.g., Aimovig, Ajovy, Vyepti);
6. If request is for a dose increase, new dose does not exceed 300 mg (3 injections) once monthly.

Approval duration: 6 months (up to a total of 12 months per cluster period)

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AZ.CP.PMN.53 for Arizona Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – AZ.CP.PMN.53 for Arizona Medicaid or evidence of coverage documents;

B. Chronic Cluster Headaches.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AHCCCS: Arizona Health Care Cost Containment System
CGRP: calcitonin gene-related peptide
FDA: Food and Drug Administration
ICHD: International Classification of Headache Disorder

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Anticonvulsants such as: divalproex (Depakote®), topiramate (Topamax®)	**Migraine Prophylaxis** *Refer to prescribing information or Micromedex*	*Refer to prescribing information or Micromedex*
Beta-blockers such as: propranolol (Inderal®), metoprolol (Lopressor®)*, timolol	**Migraine Prophylaxis** *Refer to prescribing information or Micromedex*	*Refer to prescribing information or Micromedex*
Antidepressants/tricyclic antidepressants* such as: amitriptyline (Elavil®), venlafaxine (Effexor®)	**Migraine Prophylaxis** *Refer to prescribing information or Micromedex*	*Refer to prescribing information or Micromedex*
verapamil*	**Episodic Cluster Headache**	120 mg PO TID 360 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

**Off-label use*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity
- Boxed warning(s): none reported

Appendix D: General Information

- In clinical trials, a migraine day was defined as any calendar day in which the patient reported either a headache that lasted at least 2 consecutive hours and met International Classification of Headache Disorder (ICHD)-3 diagnostic criteria for migraine (with or without aura) or probable migraine (subtype in which only 1 migraine criterion is absent), or a day when a headache of any duration was treated with migraine-specific medications (triptans or ergots).
- Although Emgality given as either 120 mg SC once monthly or 240 mg SC once monthly showed a statistically significant decrease in migraine days per month compared to placebo as the primary outcome in the EVOLVE-1, EVOLVE-2, and REGAIN pivotal trials, there was no clinically significant difference between the two dosing regimens, and thus no significant additional benefit conferred from using a higher dose of Emgality. This is consistent with the FDA-approved maintenance dose of 120 mg SC once monthly.
- According to the ICHD-3 diagnostic criteria for cluster headaches, episodic cluster headaches occur in periods lasting from seven days to one year and are separated by periods of remissions that are at least 3 months. Chronic cluster headaches (affecting 10-15% of patients), on the other hand, occur for longer than a year without remission or with a remission that lasts less than 3 months. Of note, Emgality has only demonstrated efficacy in episodic cluster headaches. It failed to meet its primary endpoint in its chronic cluster headache phase 3 trial.
- The ENFORCE Phase III clinical trial program evaluating the efficacy of Ajovy in episodic and chronic cluster headache was discontinued after a pre-specified futility analysis revealed that the study's primary endpoints were unlikely to be met.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Aimovig (erenumab-aaoe)	Migraine prophylaxis	70 mg SC once monthly Some patients may benefit from a dosage of 140 mg injected subcutaneously once monthly	140 mg/month
Ajovy (Fremanezumab-vfrm)	Migraine prophylaxis	225 mg SC once monthly or 675 mg SC every three months	675 mg every 3 months

Drug Name	Indication	Dosing Regimen	Maximum Dose
Emgality (galcanezumab-gnlm)	• Migraine prophylaxis • Episodic cluster headaches	Migraine prophylaxis: Loading dose: 240 mg SC once Maintenance dose: 120 mg SC once monthly Episodic cluster headaches: 300 mg (administered as three consecutive injections of 100 mg each) SC at the onset of the cluster period, and then monthly until the end of the cluster period	Migraine prophylaxis: 120 mg/month Episodic cluster headaches: 300 mg/month
Vyepti (Eptinezumab-jjmr)	Migraine prophylaxis	The recommended dosage is 100 mg IV every 3 months. Some patients may benefit from a dosage of 300 mg IV every 3 months.	300mg every 3 months

VI. Product Availability

Aimovig:
Single-dose prefilled SureClick® autoinjector or prefilled syringe: 70 mg/mL, 140 mg/mL

Ajovy:
Single-dose prefilled syringe: 225 mg/1.5 mL
Prefilled autoinjector: 225mg/1.5ml

Emgality:
- Single-dose prefilled pen: 120 mg/mL
- Single-dose prefilled syringe: 100 mg/mL, 120 mg/mL

Vyepti:
Single-dose vial: 100 mg/mL

VII. References

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CLINICAL POLICY
Migraine Products – Monoclonal Antibodies (Aimovig, Ajovy, Emgality, Vypeti)

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	09.28.19	10.19
1Q 2020 annual review: added Ajovy dosing information; added cluster headaches to section III; references reviewed and updated.	01.14.20	01.20
2Q 2020 added new dose form of Ajovy- prefilled auto-injector.	04.20	04.20
3Q2020 added Vyepti with dosing information; removed Aimovig as preferred product and added Ajovy as preferred product per State Preferred Drug List requirement effective 10/1/20.	09.01.20	07.20
1Q 2021 annual review: no significant changes; references reviewed and updated.	01.26.21	02.21
Added Care1st logo. Added verbiage to specify that criteria also applies to Care1st.	5.10.21	04.21

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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