# STEP THERAPY CRITERIA

<table>
<thead>
<tr>
<th>DRUG CLASS</th>
<th>CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAGONISTS</th>
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</thead>
<tbody>
<tr>
<td>BRAND NAME</td>
<td>(generic)</td>
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<tr>
<td></td>
<td>AIMOVIG (erenumab-aooe injection)</td>
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<tr>
<td></td>
<td>AJOVY (fremanezumab-vfrm injection)</td>
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<tr>
<td></td>
<td>EMGALITY (galcanezumab-gnlm injection)</td>
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**Status:** CVS Caremark Criteria  
**Type:** Initial Step Therapy; Post Step Therapy Prior Authorization

## POLICY

## FDA-APPROVED INDICATIONS

**Aimovig**  
Aimovig is indicated for the preventive treatment of migraine in adults.

**Ajovy**  
Ajovy is indicated for the preventive treatment of migraine in adults.

**Emgality**  
- **Migraine**  
  Emgality is indicated for the preventive treatment of migraine in adults  
- **Cluster Headache**  
  Emgality is indicated for the treatment of episodic cluster headaches in adults

### INITIAL STEP THERAPY For AIMOVIG, AJOVY, EMGALITY (except 100mg)

If the patient has filled a prescription for at least a 56 day supply of divalproex sodium, topiramate, valproate sodium, metoprolol, propranolol, timolol, atenolol, nadolol, amitriptyline, or venlafaxine within the past 730 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

### INITIAL STEP THERAPY For EMGALITY 100mg

If the patient has filled a prescription for at least a 1 day supply of sumatriptan (subcutaneous or nasal) or zolmitriptan (nasal or oral) within the past 730 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.
COVERAGE CRITERIA
The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the preventive treatment of migraine in an adult patient

AND

- The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline

OR

- The patient experienced an inadequate treatment response with an 8-week trial of any of the following:
  - Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), Antidepressants (e.g., amitriptyline, venlafaxine)

OR

- The patient experienced an intolerance or has a contraindication that would prohibit an 8-week trial of any of the following: Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), Antidepressants (e.g., amitriptyline, venlafaxine)

OR

- The request is for Emgality 100mg for treatment of episodic cluster headaches in adults

AND

- The patient has used Emgality 100mg for at least 3 weeks and had a reduction in weekly cluster headache attack frequency from baseline

OR

- The patient experienced an inadequate treatment response with sumatriptan (subcutaneous or nasal) or zolmitriptan (nasal or oral)

OR

- The patient experienced an intolerance or contraindication to sumatriptan (subcutaneous or nasal) or zolmitriptan (nasal or oral)

REFERENCES


