Pennsylvania
Department of Human Services

# Medical Assistance BULLETIN

| ISSUE DATE | EFFECTIVE DATE | NUMBER |
|---|---|---|
| November 6, 2024 | January 6, 2025 | *See below |

**SUBJECT**

Prior Authorization of Migraine Acute Treatment Agents – Pharmacy Services

**BY**

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Deputy Secretary
Office of Medical Assistance Programs

**IMPORTANT REMINDER:** All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: https://www.pa.gov/en/agencies/dhs/resources/for-providers/provider-enrollment-information/provider-enrollment-documents.html.

**PURPOSE:**

The purpose of this bulletin is to issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Migraine Acute Treatment Agents submitted for prior authorization.

**SCOPE:**

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program. The guidelines to determine the medical necessity of Migraine Acute Treatment Agents will be utilized in the fee-for-service and managed care delivery systems. Providers rendering services to MA beneficiaries in the managed care delivery system should address any questions related to the prior authorization of Migraine Acute Treatment Agents to the appropriate managed care organization.

**BACKGROUND:**

The Department of Human Services' (Department) Pharmacy and Therapeutics (P&T) Committee reviews published peer-reviewed medical literature and recommends the following:

- Preferred or non-preferred status for new drugs and products in therapeutic classes already included on the Statewide Preferred Drug List (PDL).

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| *01-25-18 | 09-25-18 | 27-25-18 | 33-25-18 |
| 02-25-18 | 11-25-18 | 30-25-18 | |
| 03-25-18 | 14-25-18 | 31-25-18 | |
| 08-25-19 | 24-25-18 | 32-25-18 | |

**COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:**

Fee-for-Service Provider Service Center: 1-800-537-8862

Visit the Office of Medical Assistance Programs website at:
https://www.pa.gov/en/agencies/dhs/departments-offices/omap-info.html

- Changes to the statuses of drugs and products on the Statewide PDL from preferred to non-preferred and non-preferred to preferred.
- Therapeutic classes of drugs and products to be added to or deleted from the Statewide PDL.
- New quantity limits.
- New guidelines or revisions to existing guidelines to evaluate the medical necessity of prescriptions submitted for prior authorization.

**DISCUSSION:**

During the September 10, 2024, meeting, the P&T Committee recommended the following revisions to the guidelines to determine medical necessity of Migraine Acute Treatment Agents:

- Removal of the guidelines related to concomitant use of more than one gepant for the acute treatment of migraine.
- Addition of gepants and botulinum toxins as examples of drugs for migraine prevention in the guidelines related to a prescription for a Migraine Acute Treatment Agent that exceeds the quantity limits.
- Addition of a guideline that for a non-preferred gepant, the beneficiary has a history of therapeutic failure of or a contraindication or an intolerance to the preferred gepants.
- Addition of guidelines for the determination of medical necessity of a request for renewal of the prior authorization of a prescription for a non-preferred Migraine Acute Treatment Agent.
- Specification that requests for renewal of the prior authorization of prescriptions that represent a therapeutic duplication require prior authorization.

The revisions to the guidelines to determine medical necessity of prescriptions for Migraine Acute Treatment Agents submitted for prior authorization, as recommended by the P&T Committee, were subject to public review and comment and subsequently approved for implementation by the Department.

**PROCEDURE:**

The procedures for prescribers to request prior authorization of Migraine Acute Treatment Agents are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Migraine Acute Treatment Agents) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs and products that require prior authorization.

**ATTACHMENTS**:

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

**RESOURCES:**

Prior Authorization of Pharmaceutical Services Handbook – SECTION I

Pharmacy Prior Authorization General Requirements
https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/pharmacy-prior-authorization-general-requirements.html

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines
https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/clinical-guidelines.html

## I. Requirements for Prior Authorization of Migraine Acute Treatment Agents

### A. Prescriptions That Require Prior Authorization

Prescriptions for Migraine Acute Treatment Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Migraine Acute Treatment Agent. See the Preferred Drug List (PDL) for the list of preferred Migraine Acute Treatment Agents at: https://papdl.com/preferred-drug-list.

2. A Migraine Acute Treatment Agent with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html.

3. A Migraine Acute Treatment Agent when there is a record of a recent paid claim for another Migraine Acute Treatment Agent in the point-of-sale on-line claims adjudication system (therapeutic duplication).

4. A prescription for a small molecule calcitonin gene-related peptide (CGRP) receptor antagonist (gepant).

5. A prescription for a serotonin (5-HT) 1F receptor agonist (ditan).

6. A prescription for an ergot alkaloid.

### B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Migraine Acute Treatment Agent, the determination of whether the requested prescription is medically necessary will take into account the whether the beneficiary:

1. For a gepant for the preventive treatment of migraine, see the prior authorization guideline related to Migraine Prevention Agents; **OR**

2. **Both** of the following:

   a. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication
   b. Has a diagnosis confirmed according to the current International Headache Society Classification of Headache Disorders;

   **AND**

3. Is age-appropriate according to FDA-approved package labeling, nationally recognized

compendia, or peer-reviewed medical literature; **AND**

4. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

5. Does not have a contraindication to the prescribed drug; **AND**

6. For a gepant for the acute treatment of migraine, **one** of the following:

   a. Has a history of therapeutic failure of at least two (5-HT $_{1B/1D}$) receptor agonists (triptans)
   b. Has a contraindication or an intolerance to the preferred triptans;

   **AND**

7. For a ditan, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred triptans; **AND**

8. For ergot alkaloids, has a history of therapeutic failure of or a contraindication or an intolerance to standard first-line abortive drugs based on headache classification as recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society); **AND**

9. For a non-preferred Migraine Acute Treatment Agent, **one** of the following:

   a. For a non-preferred triptan, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred triptans,
   b. For a non-preferred gepant, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred gepants,
   c. For non-preferred Migraine Acute Treatment Agents other than triptans and gepants (e.g., ditans, ergot alkaloids, etc.), has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents approved or medically accepted for the beneficiary's diagnosis or indication;

   **AND**

10. For therapeutic duplication, **one** of the following:

    a. Is being titrated to or tapered from another drug in the same class
    b. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical literature or national treatment guidelines;

    **AND**

11. If a prescription for a Migraine Acute Treatment Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account **all** of the following:

    a. The guidelines set forth in the Quantity Limits Chapter,

    b. Whether the beneficiary is prescribed the requested drug by **one** of the following:

        i. A neurologist
        ii. A headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS),

    c. For the acute treatment of migraine, **both** of the following:

        i. **One** of the following:

            a) The beneficiary is using the requested drug in addition to at least one drug for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody, gepant, botulinum toxin)
            b) The beneficiary has a history of therapeutic failure of or a contraindication or an intolerance to all preventive migraine drugs recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society)

        ii. Has documentation of an evaluation for the overuse of abortive drugs, including opioids.

    NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR A MIGRAINE ACUTE TREAMENT AGENT: The determination of medical necessity of a request for renewal of a prior authorization for a Migraine Acute Treatment Agent that was previously approved will take into account whether the beneficiary:

1. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

2. Does not have a contraindication to the prescribed drug; **AND**

3. Has documentation of improvement in headache pain, symptoms, or duration; **AND**

4. For a non-preferred Migraine Acute Treatment Agent, **one** of the following:

a. For a non-preferred triptan, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred triptans,
b. For a non-preferred gepant, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred gepants,
c. For non-preferred Migraine Acute Treatment Agents other than triptans and gepants (e.g., ditans, ergot alkaloids, etc.), has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents approved or medically accepted for the beneficiary's diagnosis or indication;

**AND**

5. For therapeutic duplication, **one** of the following:

   a. Is being titrated to or tapered from another drug in the same class
   b. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical literature or national treatment guidelines;

   **AND**

6. If a prescription for a Migraine Acute Treatment Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account **all** of the following:

   a. The guidelines set forth in the Quantity Limits Chapter,

   b. Whether the beneficiary is prescribed the requested drug by **one** of the following:

      i. A neurologist
      ii. A headache specialist who is certified in headache medicine by the UCNS,

   c. For the acute treatment of migraine, **both** of the following:

      i. **One** of the following:

         a) The beneficiary is using the requested drug in addition to at least one drug for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody, gepant, botulinum toxin)
         b) The beneficiary has a history of therapeutic failure of or a contraindication or an intolerance to all preventive migraine drugs recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society)

      ii. Has documentation of an evaluation for the overuse of abortive drugs, including opioids.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Migraine Acute Treatment Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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