

# STEP THERAPY CRITERIA

**DRUG CLASS** CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAGONISTS  
INJECTABLE, INTRAVENOUS INFUSION

**BRAND NAME**  
(generic)

**AIMOVIG**  
(erenumab-aooe injection)

**AJOVY**  
(fremanezumab-vfrm injection)

**EMGALITY**  
(galcanezumab-gnlm injection)

**VYEPTI**  
(eptinezumab-jjmr injection, for intravenous use)

**Status: CVS Caremark Criteria**

**Type: Initial Step Therapy with Quantity Limit;**

**Post Step Therapy Prior Authorization with Quantity Limit**

## 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

#### **Vyepti**

Vyepti is indicated for the preventive treatment of migraine in adults.

### **INITIAL STEP THERAPY with QUANTITY LIMIT\* For AIMOVIG, AJOVY, EMGALITY (except 100mg), VYEPTI**

*\*Include Rx and OTC products unless otherwise stated.*

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.

\*\*If the patient meets the initial step therapy criteria, then the initial limit criteria will apply. If the patient is requesting more than the initial quantity limit the claim will reject with a message indicating that a PA is required.

**INITIAL STEP THERAPY\* with QUANTITY LIMIT For EMGALITY 100mg**

\*Include Rx and OTC products unless otherwise stated.

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.

\*\*If the patient meets the initial step therapy criteria, then the initial limit criteria will apply. If the patient is requesting more than the initial quantity limit the claim will reject with a message indicating that a PA is required.

<b>**INITIAL LIMIT QUANTITY</b>		
<b><u>Migraine:</u></b>		
<b><u>Aimovig, Emgality</u></b>		
Aimovig 70mg (erenumab-aooe injection)	<b>1 Month Limit*</b> 2mL (2 autoinjectors or syringes x 1mL each) / 25 days	<b>3 Month Limit*</b> 6mL (6 autoinjectors or syringes x 1mL each) / 75 days
Aimovig 140mg (erenumab-aooe injection)	1mL (1 autoinjector or syringe x 1mL each) / 25 days	3mL (3 autoinjectors or syringes x 1mL each) / 75 days
Emgality 120mg (galcanezumab-gnlm injection)	2mL (2 syringes or pens x 1mL each) / 25 days	4mL (4 syringes or pens x 1mL each) / 75 days
<b><u>Ajovy</u></b>		
Ajovy 225mg (fremanezumab-vfrm injection)	<b>1 Month Limit and 3 Month Limit*</b> 4.5mL (3 autoinjectors or syringes x 1.5 mL each) / 75 days	
<b><u>Vyepti</u></b>		
Vyepti 100mg (eptinezumab-ijmr injection, for intravenous use)	<b>1 Month Limit and 3 Month Limit*</b> 3mL (3 single dose vials x 1mL each) / 75 days	
<b><u>Cluster Headache:</u></b>		
<b><u>Emgality</u></b>		
Emgality 100mg (galcanezumab-gnlm injection)	<b>1 Month Limit*</b> 3mL (3 syringes x 1mL each)/ 25 days	<b>3 Month Limit*</b> 9mL (9 syringes x 1mL each)/ 75 days
*The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.		

**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)

Quantity limits apply.

**LIMIT QUANTITY**

**Migraine:**

**Aimovig, Emgality**

	<b>1 Month Limit*</b>	<b>3 Month Limit*</b>
Aimovig 70mg (erenumab-aooe injection)	2mL (2 autoinjectors or syringes x 1mL each) / 25 days	6mL (6 autoinjectors or syringes x 1mL each) / 75 days
Aimovig 140mg (erenumab-aooe injection)	1mL (1 autoinjector or syringe x 1mL each) / 25 days	3mL (3 autoinjectors or syringes x 1mL each) / 75 days
Emgality 120mg (galcanezumab-gnlm injection)	1mL (1 syringe or pen x 1mL each) / 25 days	3mL (3 syringes or pens x 1mL each) / 75 days

**Ajovy**

	<b>1 Month Limit and 3 Month Limit*</b>
Ajovy 225mg (fremanezumab-vfrm injection)	4.5mL (3 autoinjectors or syringes x 1.5 mL each) / 75 days

**Vyepti**

	<b>1 Month Limit and 3 Month Limit*</b>
Vyepti 100mg (eptinezumab-jjmr injection, for intravenous use)	3mL (3 single dose vials x 1mL each) / 75 days

**Cluster Headache:**

**Emgality**

	<b>1 Month Limit*</b>	<b>3 Month Limit*</b>
Emgality 100mg (galcanezumab-gnlm injection)	3mL (3 syringes x 1mL each)/ 25 days	9mL (9 syringes x 1mL each)/ 75 days

*\*The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.*

**REFERENCES**

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