pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
December 12, 2018	December 17, 2018	*See below

SUBJECT

Prior Authorization of Antimigraine Agents, Other – Pharmacy Services

BY

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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: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

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 Antimigraine Agents, Other submitted for prior authorization.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program and providing services in the fee-for-service delivery system. Providers rendering services under the MA managed care delivery system should address any questions related to Antimigraine Agents, Other to the appropriate managed care organization.

BACKGROUND:

The Department of Human Services' (DHS) Drug Utilization Review (DUR) Board meets semi-annually to review provider prescribing and dispensing practices for efficacy, safety, and quality and to recommend interventions for prescribers and pharmacists through the DHS

*01-18-27	09-18-28	27-18-27	33-18-27
02-18-22	11-18-22	30-18-22	
03-18-23	14-18-23	31-18-28	
08-18-30	24-18-24	32-18-22	

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type

Visit the Office of Medical Assistance Programs Web site at
http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm

Prospective Drug Use Review and Retrospective Drug Use Review programs.

DISCUSSION:

During the September 25, 2018, DUR Board meeting, the DUR Board recommended that DHS update the requirements for prior authorization, the medical necessity guidelines, and the dose and duration of therapy for Antimigraine Agents, Other to ensure safe and appropriate utilization of ergot alkaloids and the new calcitonin gene-related peptide (CGRP) antagonists. The proposed revisions, as recommended by the DUR Board, were subject to public review and comment, and subsequently approved for implementation by DHS.

PROCEDURE:

The procedures for prescribers to request prior authorization of Antimigraine Agents, Other are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. DHS 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 Antimigraine Agents, Other) 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 that require prior authorization.

ATTACHMENTS:

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

SECTION II
Antimigraine Agents, Other

I. Requirements for Prior Authorization of Antimigraine Agents, Other

A. Prescriptions That Require Prior Authorization

Prescriptions for Antimigraine Agents, Other that meet any of the following conditions must be prior authorized:

1. A preferred or non-preferred Antimigraine Agent, Other, regardless of the quantity prescribed. See the Preferred Drug List (PDL) for the list of preferred Antimigraine Agents, Other at: https://papdl.com/preferred-drug-list.

2. An Antimigraine Agent, Other 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: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm.

B. Review of Documentation for Medical Necessity

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

1. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA) approved package insert OR a medically accepted indication

   AND

2. Is age-appropriate according to FDA-approved package labeling or nationally recognized compendia

   AND

3. Is prescribed a dose that is consistent with FDA-approved package labeling or nationally recognized compendia

   AND

4. Does not have a history of contraindication to the prescribed medication

   AND

5. For calcitonin gene-related peptide (CGRP) antagonists/inhibitors:

   a. Is prescribed the CGRP antagonist/inhibitor by or in consultation with a neurologist or headache specialist

      AND

   b. Has documentation of baseline average number of migraine days and headache days per month

      AND

   c. Has averaged four or more migraine days per month over the previous three months

      AND

   d. Has a diagnosis of migraine with or without aura confirmed according to the most current International Headache Society Classification of Headache Disorders

      AND

   e. Has a documented history of therapeutic failure to at least one preventive medication from each of the following three classes:

      i. Beta-blockers (e.g. metoprolol, propranolol, timolol)
      ii. Antidepressants (e.g. amitriptyline, venlafaxine)
      iii. Anticonvulsants (e.g. topiramate, valproic acid, divalproex)

      OR

   f. Has a documented history of contraindication or intolerance to all preventive medications from each of the following three classes:

      i. Beta-blockers (e.g. metoprolol, propranolol, timolol)
      ii. Antidepressants (e.g. amitriptyline, venlafaxine)
      iii. Anticonvulsants (e.g. topiramate, valproic acid, divalproex)

      AND

   g. Will not be using the prescribed CGRP antagonist/inhibitor concomitantly with botulinum toxin

      AND

h. For non-preferred CGRP antagonists/inhibitors, has a documented history of therapeutic failure, contraindication, or intolerance to the preferred CGRP antagonists/inhibitors

AND

6. For ergot alkaloids:

   a. Has a diagnosis of headache based on the most current International Headache Society Classification of Headache Disorders

   AND

   b. Has a documented history of trial and failure, contraindication, or intolerance to standard first-line abortive medications based on headache classification as recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology or American Academy of Family Physicians)

   AND

7. If a prescription for an Antimigraine Agent, Other is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

   NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement 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 PRESCRIPTIONS FOR AN ANTIMIGRAINE AGENT, OTHER: The determination of medical necessity of requests for prior authorization of renewals of prescriptions for Antimigraine Agents, Other that were previously approved will take into account whether the beneficiary:

1. For CGRP antagonists/inhibitors:

   a. Has a reduction in the average number of migraine days or headache days per month from baseline

OR

b. Has experienced a decrease in severity or duration of migraines

AND

c. Is prescribed the CGRP antagonist/inhibitor by or in consultation with a neurologist or headache specialist

AND

d. Is prescribed a dose that is consistent with FDA-approved package labeling or nationally recognized compendia

AND

e. Does not have a history of contraindication to the prescribed medication

AND

2. For ergot alkaloids:

a. Has experienced an improvement in headache pain control or duration

AND

b. Is prescribed a dose that is consistent with FDA-approved package labeling or nationally recognized compendia

AND

c. Does not have a history of contraindication to the prescribed medication

AND

3. If a prescription for an Antimigraine Agent, Other is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement 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 an Antimigraine Agent, Other. 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.

D. Dose and Duration of Therapy

Requests for prior authorization of Antimigraine Agents, Other will be approved as follows:

1. Initial approvals of requests for prior authorization of CGRP antagonists/inhibitors will be approved for up to 4 months of therapy.

2. Renewals of requests for prior authorization of CGRP antagonists/inhibitors will be approved for up to 6 months.

E. References

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