Pharmacy Medical Necessity Guidelines:
Migraine Medications: Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists and Triptans

Effective: April 1, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

Calcitonin Gene-Related Receptor (CGRP) Antagonists:

- **Ajovy (fremaznezumab-vfrm)** injection is indicated for the preventive treatment of migraine in adults. It is administered as either 225 mg once monthly or 675 mg every three months administered as three consecutive injections of 225 mg each. Ajovy injection is also indicated for the preventative treatment of episodic migraine in pediatric patients who are 6 to 17 years of age and who weigh 45 kilograms or more. It is administered as 225 mg once monthly.
- **Emgality (galcanezumab-gnlm)** injection is approved for two indications:
  - Emgality 100 mg/mL is indicated for the treatment of cluster headache. The recommended dose is 300 mg administered as three consecutive subcutaneous injections of 100 mg each at the onset of the cluster period, and then monthly thereafter until the end of the cluster period.
  - Emgality 120 mg/mL is indicated for the preventive treatment of migraine in adults. The recommended dose is 240 mg (administered as two consecutive 120 mg injections) as a loading dose following by monthly 120 mg subcutaneous injections
- **Nurtec ODT (rimegepant)** tablet is indicated for the acute treatment of migraine with or without aura in adults, as well as for the prevention of episodic migraines in adults.
- **Ubrelvy (ubrogepant)** tablet is indicated for the acute treatment of migraine with or without aura in adults.

Triptans

- Triptan medications (serotonin 5-HT_1 receptor agonists) are indicated for the acute treatment of migraine with or without aura in adults.
- **Almotriptan tablets** are also indicated for the acute treatment of migraine headache pain in adolescents age 12 to 17 years of age with a history of migraine with or without aura, and who have migraine attacks usually lasting 4 hours or more.
- **Rizatriptan tablets** are also indicated for the acute treatment of migraine with or without aura in pediatric patients 6 to 17 years of age.
- **Sumatriptan injection** is also indicated for the acute treatment of cluster headache episodes in adults.
- Tufts Health RITogether coverage for triptan medications is as follows:

Generic Name	Brand Name	PDL Status
Covered		
Rizatriptan oral tablet	Maxalt	Covered, QL (9 tablets/30 days)
Rizatriptan orally disintegrating tablet (ODT)	Maxalt ODT	Covered, QL (9 tablets/30 days)
Sumatriptan nasal solution	Imitrex nasal solution	Covered, QL (6 units/30 days)
Sumatriptan oral tablet	Imitrex tablet	Covered, QL (9 tablets/30 days)
Sumatriptan cartridge, autoinjector, syringe	Imitrex cartridge	Covered, QL (4 cartridges/autoinjectors/syringes/30 days)
Step Therapy		
Naratriptan oral tablet	Amerge oral tablet	ST, QL (9 tablets/30 days)
Zolmitriptan oral tablet	Zomig tablet	ST, QL (9 tablets/30 days)
Zolmitriptan orally disintegrating tablet (ODT)	Zomig ZMT	ST, QL (9 tablets/30 days)
Prior Authorization Required		
Almotriptan oral tablet	Axert tablet	PA, QL (9 tablets per 30 days)
Eletriptan oral tablet	Relpax tablet	PA, QL (9 tablets per 30 days)
Frovatriptan oral tablet	Frova tablet	PA, QL (9 tablets per 30 days)
Sumatriptan nasal spray	Tosymra nasal spray	PA, QL (6 units per 30 days)
Zolmitriptan nasal spray	Zomig Nasal Solution	PA, QL (6 units per 30 days)

COVERAGE GUIDELINES

The plan may authorize coverage of a non-preferred migraine medication when **ALL** of the following criteria for a particular regimen are met and limitations do not apply:

CGRP Receptor Antagonists and Serotonin (5-HT) 1F Receptor Agonists

Initial Approval Criteria:

Migraine Prevention:

Ajovy (fremanezumab-vfrm), Emgality 120 mg/mL (galcanezumab-gnlm), Nurtec ODT (rimegepant)

1. The Member meets ONE of the following:
    a. The Member is 18 years of age or older

    OR

    b. For Ajovy, the Member is 6 to 17 years of age and weighs greater than or equal to 45 kilograms

    AND

2. The Member has a documented diagnosis of migraine headaches

    AND

3. The Member has had an inadequate response or intolerance with an 8-week trial of two oral medications from any of the following classes:
    - Beta-adrenergic blockers (e.g., metoprolol, propranolol, timolol)
    - Antiepileptic drugs (e.g., divalproex sodium, valproic acid, topiramate)
    - Antidepressants (e.g. amitriptyline, venlafaxine)

Migraine Treatment:

Ubrelvy (ubrogepant), Nurtec ODT (rimegepant)

1. The Members is 18 years of age or older

    AND

2. Documentation that the medication will be used for **acute** treatment of migraine

    AND

3. For members with a diagnosis of chronic migraine headaches (≥15 headache days per month), there is documentation that the member is using a preventive migraine medication concurrently

    AND

4. The Member has had an inadequate response or intolerance with at least generic two triptans (e.g., sumatriptan, rizatriptan)

AND

5. Documentation that member will not use triptans concurrently with the requested medication

Emgality (galcanezumab-gnlm) 100 mg/mL

1. The Member is 18 years of age or older

AND

2. The Member has a diagnosis of cluster headache

AND

3. The Member has had an inadequate response or adverse reaction to at least two of the following medications or clinical rationale why all of the following medications are inappropriate for the member:
   a. Verapamil
   b. Glucocorticoid (e.g., prednisone, dexamethasone)
   c. Lithium
   d. Topiramate
   e. Melatonin

Reauthorization Criteria (CGRP Receptor Antagonists and Serotonin (5-HT) 1F Receptor Agonists):

1. Documentation from the prescriber that the Member has sustained positive response to therapy.

Triptans

Naratriptan, zolmitriptan tablets

1. The Member had an inadequate response or intolerance to rizatriptan and sumatriptan in a similar formulation as the requested medication (if available), or the provider indicates clinical inappropriateness of treatment with both generic sumatriptan and rizatriptan.

Almotriptan-, eletriptan-, frovatriptan-containing product or zolmitriptan nasal spray

1. The Member had an inadequate response or intolerance to sumatriptan and rizatriptan and at least one additional alternative generic triptan medication (e.g., naratriptan, zolmitriptan), or the provider indicates clinical inappropriateness of treatment with the preferred triptan medications

Tosymra (sumatriptan nasal spray)

1. The Member had an inadequate response or intolerance to generic sumatriptan nasal spray as well as zolmitriptan nasal spray and one additional generic triptan, or the provider indicates clinical inappropriateness of treatment with generic sumatriptan nasal spray, zolmitriptan nasal spray, and an additional generic triptan.

LIMITATIONS

1. Requests for brand-name products, which have AB-rated generics, will be reviewed according to Brand Name criteria

2. Coverage is limited to the following quantities:

Medication Name	Quantity Limit
Ajovy injection	1 injection per 30 days or 3 injections per 90 days
Almotriptan tablet	9 tablets per 30 days
Eletriptan tablet	9 tablets per 30 days
Emgality 120 mg/mL injection	Loading dose: 2 injections of 120 mg (total 240 mg loading dose) Maintenance: 1 injection per 30 days
Emgality 100 mg/mL injection	3 syringes per 30 days
Frovatriptan tablet	9 tablets per 30 days
Naratriptan tablet	9 tablets per 30 days
Nurtec ODT (Rimegepant) (for prevention)	16 tablets per 30 days
Nurtec ODT (rimegepant) (for acute treatment)	8 tablets per 30 days

Rizatriptan tablet, ODT	9 tablets per 30 days
Sumatriptan SC solution	4 syringes/autoinjectors/cartridges per 30 days
Sumatriptan nasal spray	6 nasal spray devices per 30 days
Sumatriptan tablet	9 tablets per 30 days
Tosymra (sumatriptan) nasal spray	6 units per 30 days
Ubrelvy (urogepant) tablets	8 tablets per 30 days
Vyepti (eptinezumab-jjmr)	3 mL per 90 days
Zolmitriptan nasal spray	6 nasal spray units per 30 days
Zolmitriptan tablet, zolmitriptan ODT	9 tablets per 30 days

3. Initial coverage for Ajovy and Emgality 120 mg/mL is limited to 3 months. Requests for continuation of therapy will be approved for 12 months if reauthorization criteria are met.
4. Initial coverage for Emgality 100 mg/mL is limited to 3 months. Requests for continuation of therapy will be approved for 3 months if reauthorization criteria are met.
5. The initial coverage for Ubrelvy, Nurtec ODT, and Vyepti is limited to 6 months. Requests for continuation of therapy will be approved for 12 months if reauthorization criteria are met.
6. The Plan will not authorize coverage for a CGRP inhibitor used for migraine prevention when being used in combination with another CGRP medication used for migraine prevention.
7. Members new to the plan who are stable on a CGRP receptor antagonist or serotonin (5HT) 1F receptor agonist must meet initial approval criteria if treatment was started less than 3 months prior to the request; members must meet reauthorization criteria if the member has been stable on treatment for 3 months or more prior to the request.
8. Samples, free goods, or similar offerings of the requested medication do not qualify for an established clinical response and will not be considered for prior authorization.

CODES

None

REFERENCES

1. Ajovy (fremanezumab-vfrm) [prescribing information]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; August 2025.
2. Atlas SJ, Touchette D, Agboola F et al. Acute treatments for migraine: effectiveness and value. Institute for Clinical and Economic Review (ICER). 2020 January. URL: https://icer-review.org/material/acute-migraine-evidence-report/. Available from Internet. Accessed 2020 January 17.
3. Dodick DW, Ashina M, Brandes JL et al. ARISE: A Phase 3 randomized trial of erenumab for episodic migraine. *Cephalalgia.* 2018b; 38(6):1026-37.
4. Dodick DW, Silberstein SD, Bigal ME et al. Effect of fremanezumab compared with placebo for prevention of episodic migraine: a randomized clinical trial. *JAMA*. 2018c; 319(19):1999-2008.
5. Dodick DW. Migraine. *Lancet*. 2018a; 391(10127):1315-30.
6. Eli Lilly. Lilly announces positive results for second phase 3 study of 4imegepant for the acute treatment of migraine. 2017b August. URL: https://investor.lilly.com/news-releases/news-release-details/lilly-announces-positive-results-second-phase-3-study-lasmiditan. Available from Internet. Accessed 2018 June 4.
7. Eli Lilly. Lilly announces positive results for three phase 3 studies of galcanezumab for the prevention of episodic and chronic migraine. 2017a May. URL: https://investor.lilly.com/news-releases/news-release-details/lilly-announces-positive-results-three-phase-3-studies. Available from Internet. Accessed 2018 May 9.
8. Ellis A, Otuonye I, Kumar V et al. Calcitonin gene-related peptide (CGRP) inhibitors as preventive treatments for patients with episodic or chronic migraine: effectiveness and value. 2018 July. URL: https://icer-review.org/wp-content/uploads/2017/11/ICER_Migraine_Final_Evidence_Report_070318.pdf. Available from Internet. Accessed 2018 July 5.
9. Emgality (galcanezumab-gnlm) [prescribing information]. Indianapolis, IN: Eli Lilly and Company; March 2021.
10. Frova (frovatriptan) [prescribing information]. Malvern, PA: Endo Pharmaceuticals; August 2018.
11. Imitrex injection (sumatriptan) [prescribing information]. Durham, NC: GlaxoSmithKline; February 2023.

12. Imitrex nasal spray (sumatriptan) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; December 2017.
13. Imitrex tablets (sumatriptan) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; December 2020.
14. Institute for Clinical and Economic Review (ICER). Overview of the ICER value assessment framework and update for 2017-2019. 2017a. URL: http://icer-review.org/wp-content/uploads/2017/06/ICER-value-assessment-framework-Updated-050818.pdf. Available from Internet. Accessed 2018 June 5.
15. International Headache Society (IHS). The International Classification of Headache Disorders, 3rd edition (ICHD-3). *Cephalalgia*. 2018; 38(1):1-211.
16. Lipton RB, McGinley JS, Shulman KJ et al. Faster improvement in migraine pain intensity and migraine-related disability at early time points with AVP-825 (sumatriptan nasal powder delivery system) versus oral sumatriptan: a comparative randomized clinical trial across multiple attacks from the COMPASS study. *Headache*. 2017; 57(10):1570-82.
17. Loder E, Burch R, and Rizzoli P. The 2012 AHS/AAN guidelines for prevention of episodic migraine: a summary and comparison with other recent clinical practice guidelines. *Headache*. 2012; 52(6):930-45.
18. Loder E. Fixed drug combinations for the acute treatment of migraine: place in therapy. *CNS Drugs*. 2005; 19(9):769-84.
19. Marmura MJ, Silberstein SD, and Schwedt TJ. The acute treatment of migraine in adults: the American Headache Society evidence assessment of migraine pharmacotherapies. *Headache*. 2015; 55(1):3-20.
20. Maxalt and Maxalt-MLT (rizatriptan) [prescribing information]. Jersey City, NJ: Organon &Co.; June 2021.
21. Naratriptan tablet [prescribing information]. Princeton, NJ: Bionpharma Inc.; April 2022.
22. Nurtec ODT (rimegepant) [prescribing information]. New York, NY: Pfizer Labs; April 2024.
23. Oskoui M, Pringsheim T, Billinghurst L, et al. Practice guideline update summary: pharmacologic treatment for pediatric migraine prevention: report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology and the American Headache Society. *Neurology* 2019;93:500–509.
24. Relpax (eletriptan) [prescribing information]. New York, NY: Pfizer Inc; March 2020.
25. Schwedt TJ. Chronic migraine. *BMJ*. 2014; 348:g1416.
26. Tosymra (sumatriptan) [prescribing information]. Maple Grove, MN: Upsher-Smith Laboratories, LLC; February 2021.
27. Ubrelvy (ubrogepant) [prescribing information]. North Chicago, IL: AbbVie Inc.; June 2023.
28. Zomig (zolmitriptan) nasal spray [prescribing information]. Bridgewater, NJ: Amneal Specialty; May 2019.
29. Zomig (zolmitriptan) tablet [prescribing information]. Bridgewater, NJ: Amneal Specialty; March 2022.

APPROVAL HISTORY

October 11, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. October P&T e-vote: Effective January 1, 2024, removed Aimovig from the MNG as drug is moving to noncovered status. Updated RxUM fax number. Updated previous trial language for the triptan agents.
2. March 12, 2024: Effective April 1, 2024, removed Reyvow from MNG due to product being moved to noncovered status. Updated MNG title to remove "Serotonin (5HT) Receptor Agonists" due to Reyvow's removal from guideline.
3. March 11, 2025: No changes
4. March 10, 2026: Effective April 1, 2026, updated Overview and coverage criteria for Ajovy to include expanded indication in the preventative treatment of episodic migraine in pediatric patients who are 6 to 17 years of age and who weighs 45 kg or more.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for

selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services