Triptan Medications

Almotriptan (Axert); Eletriptan (Relpax); Frovatriptan (Frova); Naratriptan; Rizatriptan; Zolmitriptan (Zomig spray)

Effective: 10/1/15

<table>
<thead>
<tr>
<th>Clinical documentation and prior authorization required</th>
<th>✓</th>
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<tbody>
<tr>
<td>Not covered</td>
<td>Type of review – case management</td>
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<tr>
<td>Pharmacy (RX) or medical (MED) benefit</td>
<td>✓</td>
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OVERVIEW

FDA-APPROVED INDICATIONS

Triptan medications (serotonin 5-HT\textsubscript{1} receptor agonists) are indicated for the acute treatment of migraine with or without aura in adults.

Axert (almotriptan) tablets are also indicated for the acute treatment of migraine headache pain in adolescents age 12 to 17 years 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.

PHARMACY COVERAGE GUIDELINES

Tufts Health Plan – Network Health may authorize coverage of a non-preferred triptan medication for members when all the following criteria for a particular regimen are met and limitations do not apply:

If the request is for a naratriptan-, rizatriptan-, or zolmitriptan-containing medication,

- The member tried and failed therapy with sumatriptan in a similar formulation as the requested medication, or the provider indicates clinical inappropriateness of treatment with sumatriptan.

If the request is for Axert, Frova, Relpax,

- The member tried and failed therapy with sumatriptan and at least one additional alternative generic triptan medication (e.g., naratriptan, rizatriptan, zolmitriptan), or the provider indicates clinical inappropriateness of treatment with the preferred triptan medications.

Upon renewal,

- The member had an office visit and has been re-assessed for this condition within the past year, and continued therapy with this medication is considered medically necessary.

LIMITATIONS

- The coverage of triptan medications is limited to 9 tablets per 30 days.
- Requests for quantities that exceed the quantity limit will be reviewed according to the Quantity Limit criteria.
- The length of approval will be for 2 years; subsequent approval will require a new authorization.
- Requests for brand-name products, which have AB-rated generics, will be reviewed according to Brand Name criteria.

CODES

None

REFERENCES

1. Imitrex tablets (sumatriptan) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; March 2012.
5. Axert (almotriptan) [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals Inc; August 2014.
7. Frova (frovatriptan) [prescribing information]. Malvern, PA: Endo Pharmaceuticals; October 2013.

APPROVAL HISTORY
- 05/12/15: Reviewed by the Pharmacy and Therapeutics Committee; approval duration modified to 2 years; renewal criteria added; criteria for naratriptan and rizatriptan modified to only require a trial w/ sumatriptan for approval; criteria for Axert, Frova and Relpax modified to require a trial w/ sumatriptan and one alternative generic triptan prior to approval; included provider indication of clinical inappropriateness of therapy with the preferred medication(s) as criteria for approval.
- 06/14/14: Reviewed by the Pharmacy and Therapeutics Committee.

BACKGROUND, PRODUCT, AND DISCLAIMER INFORMATION
Pharmacy Medication Request Guidelines have been developed for determining coverage for Tufts Health Plan – Network Health benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with the applicable Member Handbook and in coordination with the member’s physician(s). Pharmacy Medication Request 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 Tufts Health Plan – Network Health service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan – Network Health reviews Pharmacy Medication Request Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medication Request Guidelines apply to all insured offerings unless otherwise noted in this policy or the applicable Member Handbook. Check the applicable Preferred Drug List (formulary) in the pharmacy section of our website to determine if the drug requires you to get prior authorization.

For Tufts Health Unify (Medicare-Medicaid One Care for people ages 21 – 64), please refer to the Tufts Health Unify Prior Authorization Medical Necessity Guidelines.

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.