STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

LASMIDITAN

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
LASMIDITAN SUCCINATE	REYVOW	46082		GPI-10 (6740654060)	

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Is the request for the acute treatment of migraine and the patient meets **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - The patient had a trial of or contraindication to **ONE** triptan (e.g., sumatriptan, rizatriptan)

   If yes, **approve for 6 months for the requested strength by GPID OR GPI-14 as follows:**
   - **50mg: #8 per 30 days.**
   - **100mg: #8 per 30 days.**

   APPROVAL TEXT: Renewal requires that the request is for acute treatment of migraines and the patient has experienced an improvement from baseline in a validated acute treatment patient-reported outcome questionnaire (e.g., Migraine Assessment of Current Therapy [Migraine-ACT]) OR the patient has experienced clinical improvement as defined by ONE of the following: 1) ability to function normally within 2 hours of dose, 2) headache pain disappears within 2 hours of dose, or 3) therapy works consistently in majority of migraine attacks.

   If no, do not approve.
   INITIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **LASMIDITAN (Reyvow)** requires the following rule(s) be met for approval:
   A. You are being treated for acute (quick onset) migraine
   B. You are 18 years of age or older
   C. You have previously tried ONE triptan (such as sumatriptan, rizatriptan), unless there is a medical reason why you cannot (contraindication)

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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LASMIDITAN

GUIDELINES FOR USE (CONTINUED)

RENEWAL CRITERIA

1. Is the request for the acute treatment of migraine and the patient meets **ONE** of the following criteria?
   - The patient has experienced an improvement from baseline in a validated acute treatment patient-reported outcome questionnaire (e.g., Migraine Assessment of Current Therapy [Migraine-ACT])
   - The patient has experienced clinical improvement as defined by **ONE** of the following:
     - o Ability to function normally within 2 hours of dose
     - o Headache pain disappears within 2 hours of dose
     - o Therapy works consistently in majority of migraine attacks

   If yes, **approve for 12 months for the requested strength by GPID or GPI-14 as follows:**
   - **50mg: #8 per 30 days.**
   - **100mg: #8 per 30 days.**

   If no, do not approve.
   RENEWAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **LASMIDITAN (Reyvow)** requires the following rule(s) be met for renewal:
   A. You are being treated for acute (quick onset) migraine
   B. You meet ONE of the following:
      1. You have experienced an improvement from baseline in a validated acute treatment patient-reported outcome questionnaire (assessment tool used to help guide treatment such as Migraine Assessment of Current Therapy [MIGRAINE-ACT])
      2. You have experienced clinical improvement as defined by ONE of the following:
         a. Ability to function normally within 2 hours of dose
         b. Headache pain disappears within 2 hours of dose
         c. Treatment works consistently in majority of migraine attacks

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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LASMIDITAN

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Reyvow.

REFERENCES

- Reyvow [Prescribing Information]. Indianapolis, IN: Lilly USA, LLC, January 2020.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 12/12/20

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P&T Approval: 01/20