FREMANEZUMAB-VFRM

Generic	Brand	HICL	GCN	Exception/Other
FREMANEZUMAB-VFRM	AJOVY	45236		

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Does the patient have a diagnosis of episodic migraines and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - Ajovy is prescribed for the preventive treatment of migraines
   - The patient has had a previous trial of at least **ONE** of the following preventative migraine treatments: Valproic acid/divalproex sodium, topiramate, propranolol, timolol, amitriptyline, venlafaxine, atenolol, nadolol
   - The patient has had a previous trial of Aimovig **AND** Emgality

   If yes, **approve for 6 months by HICL with a quantity limit of #1.5mL (1 syringe) per 30 days.**
   APPROVAL TEXT: Renewal requires that the patient has experienced a reduction in migraine or headache frequency of at least 2 days per month, **OR** that the patient has experienced a reduction in migraine severity **OR** migraine duration with Ajovy therapy

   If no, continue to #2.

2. Does the patient have a diagnosis of chronic migraines and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - Ajovy is prescribed for the preventive treatment of migraines
   - The patient has had a previous trial of at least **ONE** of the following preventative migraine treatments: Valproic acid/divalproex sodium, topiramate, propranolol, timolol, amitriptyline, venlafaxine, atenolol, nadolol, or Botox **[Note: For Botox, previous trial of only NDCs # 00023-1145-01 or 00023-3921-02 are allowable]**
   - The patient has had a previous trial of Aimovig **AND** Emgality

   If yes, **approve for 6 months by HICL with a quantity limit of #1.5mL (1 syringe) per 30 days.**
   APPROVAL TEXT: Renewal requires that the patient has experienced a reduction in migraine or headache frequency of at least 2 days per month, **OR** that the patient has experienced a reduction in migraine severity **OR** migraine duration with Ajovy therapy.

   If no, do not approve.
   DENIAL TEXT: See the initial denial text at the end of the guideline

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INITIAL CRITERIA (CONTINUED)

INITIAL DENIAL TEXT: The guideline named **FREMANEZUMAB-VFRM (Ajovy)** requires a diagnosis of migraines. The following criteria must also be met:

For episodic migraines, approval requires:

- The patient is 18 years of age or older
- Ajovy is prescribed for the preventive treatment of migraines
- The patient has had a previous trial of at least ONE of the following preventative migraine treatments: Valproic acid/divalproex sodium, topiramate, propranolol, timolol, amitriptyline, venlafaxine, atenolol, nadolol
- . The patient has had a previous trial of Aimovig **AND** Emgality

For chronic migraines, approval requires:

- The patient is 18 years of age or older
- Ajovy is prescribed for the preventive treatment of migraines
- The patient has had a previous trial of at least ONE of the following preventative migraine treatments: Valproic acid/divalproex sodium, topiramate, propranolol, timolol, amitriptyline, venlafaxine, atenolol, nadolol, or Botox [Note: For Botox, previous trial of only NDCs # 00023-1145-01 or 00023-3921-02 are allowable]
- The patient has had a previous trial of Aimovig **AND** Emgality

RENEWAL CRITERIA

1. Is Ajovy being prescribed for the preventive treatment of migraines **AND** does the patient meet at least **ONE** of the following criteria?
   - The patient has experienced a reduction in migraine or headache frequency of at least 2 days per month with Ajovy therapy
   - The patient has experienced a reduction in migraine severity with Ajovy therapy
   - The patient has experienced a reduction in migraine duration with Ajovy therapy

   If yes, **approve for 12 months by HICL with a quantity limit of #1.5mL (1 syringe) per 30 days.**

   If no, do not approve.
   RENEWAL DENIAL TEXT: The guideline named **FREMANEZUMAB-VFRM (Ajovy)** requires that Ajovy is being prescribed for preventive treatment of migraines. At least **ONE** of the following criteria must also be met:
   - The patient has experienced a reduction in migraine or headache frequency of at least 2 days per month with Ajovy therapy
   - The patient has experienced a reduction in migraine severity with Ajovy therapy
   - The patient has experienced a reduction in migraine duration with Ajovy therapy

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RATIONALE

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

REFERENCES

- Ajovy [Prescribing Information]. North Wales, PA: Teva Pharmaceuticals USA, Inc. September 2018.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 01/01/20
Created: 09/18
Client Approval: 11/19
P&T Approval: 10/19