

DRAFT

Therapeutic Class Code: H3F

Therapeutic Class Description: Antimigraine Preparations

Medication
Amerge, naratriptan
almotriptan
Frova, frovatriptan
Imitrex, Migranow Kit, sumatriptan, Sumavel Dose Pro, Onzetra Xsail, Tosymra, Zembrace Symtouch
Maxalt/Maxalt-MLT, rizatriptan, rizatriptan ODT
Relpax, eletriptan
Treximet, sumatriptan/naproxen
Zomig/ Zomig ZMT, zolmitriptan, zolmitriptan ODT

Eligible Beneficiaries

NC Medicaid (Medicaid) beneficiaries shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NCHC) beneficiaries, ages 6 through 18 years of age, shall be enrolled on the date of service to be eligible, and must meet policy coverage criteria, unless otherwise specified.

EPSDT does not apply to NCHC beneficiaries.

EPSDT Special Provision: Exception to Policy Limitations for Beneficiaries under 21 Years of Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the

**NC Division of Medical Assistance
Outpatient Pharmacy
Prior Approval Criteria Triptans**

**Medicaid and Health Choice
Effective Date: July 20, 2009
Amended Date: April 13, 2021**

- treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers. EPSDT does not require the state Medicaid agency to provide any service, product, or procedure
- a. that is unsafe, ineffective, or experimental/investigational.
 - b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

- a. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing Assistance Guide, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services-right-you/medicaid-benefit-children-and-adolescents>

Health Choice Special Provision: Exceptions to Policy Limitations for Health Choice Beneficiaries ages 6 through 18 years of age

EPSDT does not apply to NCHC beneficiaries. If a NCHC beneficiary does not meet the clinical coverage criteria within the **Outpatient Pharmacy prior approval** clinical coverage criteria, the NCHC beneficiary shall be denied services. Only services included under the Health Choice State Plan and the DMA clinical coverage policies, service definitions, or billing codes shall be covered for NCHC beneficiaries.

Criteria

The following criteria must be met to exceed 12 units (doses) **per month** of a Triptan (oral tablets, nasal sprays, injections).

If different types of Triptans are required in a single month, the total maximum number of allowable units that can be obtained without prior approval remains the same. The same criteria must be fulfilled to obtain more than 12 units (doses) **per month** of combined products:

1. Documentation in beneficiary chart of diagnostic criteria for migraine headache or cluster headache.
AND
2. Greater than six moderate or severe headache days a month.
AND
3. Beneficiary must have tried and failed nonsteroidal anti-inflammatory (NSAIDS) within the last year or currently using NSAIDS, unless contraindicated.
AND
4. Beneficiary must concurrently be using migraine preventative medication(s) (i.e. Beta-Blockers, Tricyclic Antidepressants, Anticonvulsants) unless contraindicated, adverse effects occurred or no clinical benefit occurred after at least a 90 day trial at maximum tolerated dose.
AND
5. Beneficiary must not have history, symptoms, or signs of ischemic cardiac, cerebrovascular, or peripheral vascular syndromes; cardiovascular diseases; any type of angina pectoris, myocardial infarction(MI), or strokes; silent myocardial ischemia; transient ischemic attacks; ischemic bowel disease; uncontrolled hypertension; concurrent MAO-A inhibitor therapy (or within 2 weeks of discontinuing MAO-A inhibitor therapy); concurrent use of (or use within 24 hours of) ergotamine-containing or ergot-type medication; concurrent use within 24 hours of another 5-HT1 agonist; or hemiplegic or basilar migraine.
AND
6. Prescribing clinician has reviewed recommendations below based on evidence based studies.

Recommendations from Evidence Based Studies

- Recommendation 1:** For most migraine sufferers, nonsteroidal anti-inflammatory drugs(NSAIDs) are first line therapy
- Recommendation 2:** In patients whose migraine headaches do not respond to NSAIDs, use migraine specific therapy (triptans, dihydroergotamines)
- Recommendation 3:** Select a non-oral route of administration for patients whose migraines present early with nausea or vomiting as a significant component of the symptom complex. Treat nausea and vomiting with an anti-emetic.
- Recommendation 4:** Migraine sufferers should be evaluated for use of preventive therapy.
- Recommendation 5:** Recommended first line agents for prevention of headaches are Beta Blockers, Tricyclic Antidepressants, and Anticonvulsants.
- Recommendation 6:** Educate migraine sufferers about the control of acute attacks and preventive therapy and engage them in the formulation of a management plan. Therapy should be re-evaluated on a regular basis.

Procedures

Length of therapy may be approved up to 12 months.

References

1. Snow V, Weiss K, Wall EM, Mottur-Pilson C. Pharmacologic management of acute attacks of migraine and prevention of migraine headache. Ann Intern Med. 2002. 137:840-849
2. Silberstein SD. Practice parameter: evidence based guidelines for migraine headaches (an evidence based review): report of the quality standards subcommittee of the American Academy of Neurology. Neurology 2000. 55:754-762
3. Treatment of primary headache: preventive treatment of migraine. Standards of care for headache diagnosis and treatment. 2004. National Guideline Clearinghouse. www.guideline.gov.
4. Drug Effectiveness Review Project. Oregon Health Sciences University. Triptan Final Report 2005. viewed on 1-08 at www.ohsu.edu/drugeffectiveness/reports/

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Criteria Change Log

07/20/2009	Criteria effective date
06/15/2012	Combined NC Medicaid and NC Health Choice criteria into one and add coverage for Sumavel
08/15/2014	Add coverage criteria for Alsuma
12/04/2014	Add GCN for Sumavel
09/22/2015	Add GCN for Zomig
04/13/2021	Remove GCNs, Remove Alsuma & Axert, Add frovatriptan, Migranow Kit, Onzetra Xsail, Tosymra, Zembrace Syntouch, rizatriptan, ODT, eletriptan, sumatriptan/naproxen, zolmitriptan ODT
xx/xx/xxxx	Clarify that limit is 12 per MONTH