

## **Clinical Policy: Ubrogapant (Ubrelvy)**

Reference Number: MDN.CP.PHAR.476

Effective Date: 04.01.22

Last Review Date: 04.22

Line of Business: Illinois Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Ubrogapant (Ubrelvy<sup>™</sup>) is a calcitonin gene-related peptide (CGRP) receptor antagonist.

### **FDA Approved Indication(s)**

Ubrelvy is indicated for the acute treatment of migraine with or without aura in adults.

Limitation(s) of use: Ubrelvy is not indicated for the preventive treatment of migraine.

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Ubrelvy is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Migraines (must meet all):**

1. Diagnosis of migraine headaches;
2. Age  $\geq$  18 years;
3. Failure of at least TWO formulary 5HT<sub>1B/1D</sub>-agonist migraine medications (e.g., sumatriptan, rizatriptan) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
4. For requests for monthly quantities > 1 box of 10 tablets per month, member meets all of the following (a, b, and c):
  - a. Failure of TWO oral migraine prophylactic therapies from different therapeutic classes, each for 8 weeks, unless clinically significant adverse effects are experienced or all are contraindicated (*see Appendix B*);
  - b. Prescribed by or in consultation with a neurologist, headache, or pain specialist;
5. Dose does not exceed 200 mg (2 tablets) per day and 8 days per month.

**Approval duration: 6 months**

##### **B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

#### **II. Continued Therapy**

**A. Migraines (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. For dose increase requests to quantities > 1 box of 10 tablets per month, member meets all of the following (a, b, and c):
  - a. Failure of at least TWO oral migraine prophylactic therapies from different therapeutic classes, each for 8 weeks, unless clinically significant adverse effects are experienced or all are contraindicated (*see Appendix B*);
  - b. Prescribed by or in consultation with a neurologist, headache, or pain specialist;
4. If request is for a dose increase, new dose does not exceed 200 mg (2 tablets) per day and 8 days per month.

**Approval duration: 12 months**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.  
**Approval duration: Duration of request or 12 months (whichever is less);** or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid, or evidence of coverage documents

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

5-HT: serotonin

AAN: American Academy of Neurology

CGRP: calcitonin gene-related peptide

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

Abortive Migraine Therapy		
Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<i><b>Triptans</b></i>		
sumatriptan (Imitrex <sup>®</sup> nasal spray)	One spray (5 to 20 mg) at onset into one nostril; can be repeated in 2 hours	40 mg/day
sumatriptan (Imitrex <sup>®</sup> )	One tablet (25 to 100 mg) PO at onset; can be repeated in two hours	200 mg/day

Abortive Migraine Therapy		
Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
rizatriptan (Maxalt <sup>®</sup> / Maxalt MLT <sup>®</sup> )	One tablet (5 or 10 mg) PO at onset of migraine headache; can be repeated in two hours	30 mg/day
Prophylactic Migraine Therapy		
Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<b>Antiepileptic Drugs**</b>		
divalproex sodium (Depakote <sup>®</sup> )	500 to 1,000 mg/day PO	1,000 mg/day
divalproex sodium ER (Depakote <sup>®</sup> ER)	500 to 1,000 mg/day PO	1,000 mg/day
topiramate (Topamax <sup>®</sup> )	100 mg/day PO	100 mg/day
<b>Beta-Blockers</b>		
metoprolol (Lopressor <sup>®</sup> )	200 mg/day PO	200 mg/day
propranolol (Inderal <sup>®</sup> )	80 to 240 mg/day PO	240 mg/day
timolol (Blocadren <sup>®</sup> )	20 to 30 mg/day PO	30 mg/day
atenolol (Tenormin <sup>®</sup> )	100 mg/day PO	100 mg/day
nadolol (Corgard <sup>®</sup> )	80 to 240 mg/day PO	240 mg/day
<b>Serotonin Reuptake Inhibitors</b>		
venlafaxine XR (Effexor XR <sup>®</sup> )	150 mg/day PO	150 mg/day
<b>Tricyclic Antidepressants</b>		
amitriptyline (Elavil <sup>®</sup> )	30 to 150 mg/day PO	150 mg/day

Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.

\*\*FDA approved.

#### Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): concomitant use with strong CYP3A4 inhibitors
- Boxed warning(s): none reported

#### Appendix D: General Information

- The AAN recommends that prophylactic migraine medications should be considered if the patient experiences 2 or more attacks per month that produce aggregate disability of 3 or more days/month.
- The AAN and the National Headache Foundation recommend that prophylactic migraine medications should be considered if one or more of the following are present: greater than 2 migraine headaches per week; migraines cause significant impairment in daily routine even with abortive treatment; contraindication to, adverse effects, overuse or failure of abortive migraine medications, presence of uncommon migraine condition (e.g., basilar migraine); or patient requesting prophylactic therapy.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Migraines	50 or 100 mg PO, as needed. If needed, a second dose may be administered at least 2 hours after the initial dose. The maximum dose in a 24-hour period is 200 mg.	200 mg/day

**VI. Product Availability**

Tablets (package size 10, 12, 30): 50 mg, 100 mg

**VII. References**

1. Ubrelvy Prescribing Information. Madison, NJ: Allergan USA, Inc.; December 2019. Available at: [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2019/211765s000lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/211765s000lbl.pdf). Accessed September 15, 2021.
2. Dodick DW, Lipton RB, Ailani J, et al. Ubrogapant for the treatment of migraine. N Engl J Med 2019 Dec 5; 381:2230-41.
3. Lipton RB, Dodick DW, Ailani J, et al. Effect of ubrogapant vs placebo on pain and the most bothersome associated symptom in the acute treatment of migraine: the ACHIEVE II randomized clinical trial. JAMA 2019; 322(10):1887-98.
4. American Headache Society. The American Headache Society position statement on integrating new migraine treatments into clinical practice. Headache. 2019;59:1-18.
5. MICROMEDEX<sup>®</sup> Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed September 15, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created, adapted from CP.PHAR.476 to align with HFS PDL	03.18.22	04.22

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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