Clinical Policy: Atogepant (Qulipta)

Reference Number: MDN.CP.PHAR.566
Effective Date: 04.01.22
Last Review Date: 10.25.26
Line of Business: Meridian Illinois Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Atogepant (Qulipta™) is a calcitonin gene-related peptide receptor (CGRP) antagonist.

FDA Approved Indication(s)

Qulipta™ is indicated for the preventative treatment of episodic migraine in adults.

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® that Qulipta™ is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Migraine Prophylaxis (must meet all)**:**

1. Diagnosis of episodic or chronic migraine;
2. Failure of at least 2 of the following oral agents, unless clinically significant adverse effects are experienced or all are contraindicated; antiepileptic drugs (e.g., divalproex sodium, sodium valproate, topiramate), beta-blockers (e.g. metoprolol, propranolol, timolol), antidepressants (e.g., amitriptyline, venlafaxine);
3. Qulipta is not prescribed concurrently with other CGRP inhibitors (e.g., Aimovig, Ajovy, Emgality, Nurtec® ODT, Ubrelvy™, Vyepti, Zavzpret™);
4. Dose does not exceed 60 mg (1 tablet) per day.

Approval duration: 6 months

B. Other diagnoses/indications

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy for the relevant line of business: and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Migraine Prophylaxis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member has experienced and maintained positive response to therapy as evidenced by a reduction in migraine days per months from baseline;
3. Qulipta is not prescribed concurrently with other CGRP inhibitors (e.g., Aimovig, Ajovy, Emgality, Nurtec® ODT, Ubrelvy™, Vyepti, Zavzpret™);
4. If request is for a dose increase, new dose does not exceed 60 mg (1 tablet) per day.

Approval duration: 12 months

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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

AAN: American Academy of Neurology
AHS: American Headache Society
CGRP: Calcitonin gene-related peptide
FDA: Food and Drug Administration
MHD: Monthly Headache Day
MMD: Monthly Migraine Days

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Anticonvulsants such as: divalproex (Depakote®), topiramate (Topamax®), valproate sodium	**Migraine Prophylaxis** *Refer to prescribing information or Micromedex*	*Refer to prescribing information or Micromedex*
Beta-blockers such as: propranolol (Inderal®), metoprolol (Lopressor®)*, timolol, atenolol (Tenormin®)*, nadolol (Corgard®)*	**Migraine Prophylaxis** *Refer to prescribing information or Micromedex*	*Refer to prescribing information or Micromedex*
Antidepressants/tricyclic antidepressants* such as: amitriptyline (Elavil®), venlafaxine (Effexor®)	**Migraine Prophylaxis** *Refer to prescribing information or Micromedex*	*Refer to prescribing information or Micromedex*

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

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): history of hypersensitivity to atogepant or to any of the components of Qulipta
- Boxed warning(s): None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Episodic migraine prophylaxis	10 mg, 30 mg, or 60 mg PO QD	60 mg/day
Chronic Migraine prophylaxis	60 mg PO QD	60 mg/day

VI. Product Availability

Tablet: 10 mg, 30 mg, 60 mg

VII. References

1. Qulipta Prescribing Information. Dublin, Ireland: Allergan Pharmaceuticals International Limited, and AbbVie company; September 2025. Available at https://www.quliptahcp.com/. Accessed July 9, 2026.
2. Pozo-Rosich P, Ailani J, Ashina M, et al. Atogepant for the preventive treatment of chronic migraine (PROGRESS): a randomised, double-blind, placebo-controlled, phase 3 trial. Lancet. 2023 Sep 2;402(10404):775-785.
3. Silberstein SD, Holland S, Freitag F, Dodick DW, Argoff C, Ashman E. Evidence-based guideline update: Pharmacologic treatment for episodic migraine prevention in adults: Report of the Quality Standards Subcommittee of the American Academy of Neurology and the American Headache Society. Neurology. 2012; 78: 1337-1345.
4. American Headache Society. The American Headache Society position statement on integrating new migraine treatments into clinical practice. Headache. 2019; 59:1-18.
5. Pringsheim T, Davenport WJ, Becker WJ. Prophylaxis of migraine headache. CMAJ. 2010;182(7):E269-E276. doi:10.1503/cmaj.081657.

6. ClinicalTrials.gov. 12-Week Placebo-controlled Study of Atogepant for the Preventative Treatment of Migraine in Participants with Episodic Migraine. July 9, 2021. Available at https://www.clinicaltrials.gov/ct2/show/results/NCT03777059. Accessed July 20, 2026.
7. ClinicalTrials.gov. Efficacy, Safety, and Tolerability of Multiple Dosing Regimens of Oral Atogepant (AGN-241689) in Episodic Migraine Prevention. Available at https://clinicaltrials.gov/ct2/show/NCT02848326. December 6, 2018.Accessed July 20, 2026.
8. Ailani J, Lipton RB, Goadsby PJ, Guo H, Miceli R, Severt L, Finnegan M, Trugman JM; ADVANCE Study Group. Atogepant for the Preventive Treatment of Migraine. N Engl J Med. 2021 Aug 19;385(8):695-706.
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10. Charles AC, Digre KB, Goadsby PJ, et al. The American Headache Society: Calcitonin generelated peptide-targeting therapies are a first-line option for the prevention of migraine: An American Headache Society position statement update. Headache. 2024; 64: 333–341.
11. Qaseem A, Cooney TG, Etxeandia-Ikobaltzeta I, et al. Prevention of Episodic Migraine Headache Using Pharmacologic Treatments in Outpatient Settings: A Clinical Guideline From the American College of Physicians. Ann Intern Med. 2025 Mar; 178(3): 426-433.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created, adapted from CP.PHAR.566 to align with HFS requirements	3.18.22	04.22
2Q 2022 annual review; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	5.15.23	
RT4:Policy updated to incorporate expanded indication for preventive treatment of chronic migraine.	6.26.23	
4Q2025 Annual Review: no significant changes; references reviewed and updated.	12.3.25	
Added statement regarding duplication of therapy.	5.21.26	
4Q 2026 annual review: no significant changes; references reviewed and updated.	10.25.26	11.26

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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a

component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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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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