Pharmacy Medical Necessity Guidelines: Triptan Medications
Effective: November 21, 2016

Prior Authorization Required √ Type of Review – Care Management
Not Covered √ Type of Review – Clinical Review
Pharmacy (RX) or Medical (MED) Benefit RX Department to Review RXUM

This Pharmacy Medical Necessity Guidelines applies to the following:

Tufts Health Plan Commercial Plans
☒ Tufts Health Plan Commercial Plans – large group plans
☐ Tufts Health Plan Commercial Plans – small group and individual plans

Tufts Health Public Plans
☐ Tufts Health Direct – Health Connector
☒ Tufts Health Together – A MassHealth Plan
☐ Tufts Health RITogether – A Rite Care + Rhody Health Partners Plan

Tufts Health Freedom Plan products
☐ Tufts Health Freedom Plan - large group plans
☐ Tufts Health Freedom Plan - small group plans

Fax Numbers:
RXUM:  617-673-0988

OVERVIEW

FDA-APPROVED INDICATIONS
Triptan medications (serotonin 5-HT1 receptor agonists) are indicated for the acute treatment of migraine with or without aura in adults.

Axert (almotriptan) tablets are also indicated for the acute treatment of migraine headache pain in adolescents age 12 to 17 years of age with a history of migraine with or without aura, and who have migraine attacks usually lasting 4 hours or more.

Rizatriptan tablets are also indicated for the acute treatment of migraine with or without aura in pediatric patients 6 to 17 years of age.

Sumatriptan injection is also indicated for the acute treatment of cluster headache episodes in adults.

COVERAGE GUIDELINES
The plan may authorize coverage of a non-preferred triptan medication for Members when all the following criteria for a particular regimen are met and limitations do not apply:

If the request is for a naratriptan-, rizatriptan-, or zolmitriptan-containing medication
1. The Member tried and failed therapy with sumatriptan in a similar formulation as the requested medication, or the provider indicates clinical inappropriateness of treatment with sumatriptan

If the request is for almotriptan, frovatriptan, Relpax
1. The Member tried and failed therapy with sumatriptan and at least one additional alternative generic triptan medication (e.g., naratriptan, rizatriptan, zolmitriptan), or the provider indicates clinical inappropriateness of treatment with the preferred triptan medications

LIMITATIONS
1. The coverage of triptan medications is limited to 9 tablets per 30 days
2. Requests for brand-name products, which have AB-rated generics, will be reviewed according to Brand Name criteria

CODES
None

REFERENCES
1. Imitrex tablets (sumatriptan) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; March 2012.
5. Axert (almotriptan) [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals Inc; August 2014.
7. Frova (frovatriptan) [prescribing information]. Malvern, PA: Endo Pharmaceuticals; October 2013.

**APPROVAL HISTORY**
June 14, 2014: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
- May 12, 2015: Reviewed by the Pharmacy and Therapeutics Committee; approval duration modified to 2 years; renewal criteria added; criteria for naratriptan and rizatriptan modified to only require a trial w/ sumatriptan for approval; criteria for Axert, Frova and Relpax modified to require a trial w/ sumatriptan and one alternative generic triptan prior to approval; included provider indication of clinical inappropriateness of therapy with the preferred medication(s) as criteria for approval
- September 16, 2015: Approval duration approved for life of plan
- January 1, 2016: Administrative change to rebranded template.
- October 18, 2016: Reflected generic availability of Axert and Frova.
- November 15, 2016: administrative update; removed approval duration language
- April 11, 2017: Administrative update, Adding Tufts Health RITogether to the template

**BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**
Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member’s benefit document and in coordination with the Member’s physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member’s health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member’s benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLinkSM Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.