Pharmacy Medical Necessity Guidelines: Triptan Medications

Effective: July 20, 2020

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

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☐ Tufts Health Plan Commercial products – large group plans
☐ Tufts Health Plan Commercial products – small group and individual plans
☐ Tufts Health Freedom Plan products – large group plans
☐ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM: 617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FDA-APPROVED INDICATIONS

Triptan medications (serotonin 5-HT_1 receptor agonists) are indicated for the acute treatment of migraine with or without aura in adults.

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.

Tufts Health Together PDL status is as follows:

Generic Name	Brand Name	PDL Status
Covered		
Rizatriptan oral tablet	Maxalt	Covered, QL (9 tablets/30 days)
Rizatriptan orally disintegrating tablet	Maxalt ODT	Covered, QL (9 tablets/30 days)
Sumatriptan nasal solution	Imitrex nasal solution	Covered, QL (6 units/30 days)
Sumatriptan oral tablet	Imitrex tablet	Covered, QL (9 tablets/30 days)
Sumatriptan cartridge, autoinjector, syringe	Imitrex cartridge	Covered, QL (4 cartridges/autoinjectors/syringes/30 days)
Step Therapy		
Naratriptan oral tablet	Amerge oral tablet	ST, QL (9 tablets/30 days)
Zolmitriptan oral tablet	Zomig tablet	ST, QL (9 tablets/30 days)
Zolmitriptan orally disintegrating	Zomig ZMT	ST, QL (9 tablets/30 days)
Zolmitriptan nasal spray	Zomig Nasal Solution	ST, QL (6 units per 30 days)
Prior Authorization Required		
Almotriptan oral tablet	Axert tablet	PA, QL (9 tablets per 30 days)
Eletriptan oral tablet	Relpax tablet	PA, QL (9 tablets per 30 days)
Frovatriptan oral tablet	Frova tablet	PA, QL (9 tablets per 30 days)
Sumatriptan nasal spray	Tosymra	PA, QL (6 units per 30 days)

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-, or zolmitriptan-containing medication

1. The Member tried and failed therapy with both rizatriptan and sumatriptan in a similar formulation as the requested medication (if available), or the provider indicates clinical inappropriateness of treatment with both rizatriptan and sumatriptan

If the request is for almotriptan, eletriptan, or frovatriptan

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

If the request is for Tosymra (sumatriptan nasal spray)

1. The Member tried and failed therapy with generic sumatriptan nasal spray and zolmitriptan nasal spray, or the provider indicates clinical inappropriateness of treatment with generic sumatriptan nasal spray and zolmitriptan nasal spray.

LIMITATIONS

1. The coverage of triptan tablets is limited to 9 tablets per 30 days
2. The coverage of sumatriptan subcutaneous solution is limited to four syringes/autoinjectors/cartridges per 30 days.
3. The coverage of sumatriptan nasal spray is limited to 6 nasal spray devices per 30 days.
4. The coverage of zolmitriptan nasal spray is limited to 6 nasal spray units per 30 days.
5. 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; December 2017.
2. Imitrex nasal spray (sumatriptan) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; December 2017.
3. Amerge (naratriptan) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; November 2016.
4. Maxalt (rizatriptan) [prescribing information]. Whitehouse Station, NJ: Merck and Co; January 2013.
5. Zomig (zolmitriptan) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals; September 2012.
6. Axert (almotriptan) [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals Inc; May 2017.
7. Relpax (eletriptan) [prescribing information]. New York, NY: Pfizer Inc; November 2013.
8. Frova (frovatriptan) [prescribing information]. Malvern, PA: Endo Pharmaceuticals; August 2018.
9. Tfelt-Hansen P, De Vries P, Saxena PR. Triptans in migraine: a comparative review of pharmacology, pharmacokinetics and efficacy. Drugs. 2000;60(6):1267.
10. Tosymra (sumatriptan) [prescribing information]. Princeton, NJ: Promius Pharm; January 2019.

APPROVAL HISTORY

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

Subsequent endorsement date(s) and changes made:

1. 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
2. September 16, 2015: Approval duration approved for life of plan
3. January 1, 2016: Administrative change to rebranded template.
4. October 18, 2016: Reflected generic availability of Axert and Frova.

5. November 15, 2016: administrative update; removed approval duration language
6. May 9, 2017: Administrative update, Adding Tufts Health RITogether to the template
7. December 12, 2017: Administrative update, reflected the generic availability of Relpax (eletriptan)
8. December 11. 2018: Administrative update, added quantity limits for all the triptan medications. Administrative changes made to template.
9. July 9, 2019: Administrative update, added the PDL status of the triptans to the background section of the MNG.
10. October 15, 2019: Added criteria for Tosymra (sumatriptan) nasal spray to the MNG.
11. April 14, 2020: Effective 4/20/20, updated the MNG to reflect that rizatriptan tablet and orally disintegrating tablet are now covered without PA. Updated criteria for naratriptan- and zolmitriptan-containing products to include rizatriptan as a trial option. Effective 7/1/2020, updated criteria for naratriptan-, zolmitriptan-, eletriptan-, frovatriptan-, and almotriptan-containing products to require trial and failure with both sumatriptan and rizatriptan.
12. July 14, 2020: Effective 7/20/20, MNG is retired. Criteria for triptan medications is being moved to MNG titled "Migraine Medications."

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. 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.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

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.

Provider Services