

Clinical Policy: Fremanezumab-vfrm (Ajovy)

Reference Number: DE.PHAR.403

Effective Date: 01.23

Last Review Date: 01.23

Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

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

Description

Fremanezumab-vfrm (Ajovy®) is a calcitonin gene-related peptide (CGRP) receptor antagonist.

FDA Approved Indication(s)

Ajovy is indicated for the preventive treatment of 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 Ajovy 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. Member experiences ≥ 4 migraine days per month for at least 3 months;
3. Prescribed by or in consultation with a neurologist, headache, or pain specialist;
4. Age ≥ 18 years;
5. Failure of at least 3 of the following oral migraine preventative therapies, each for 8 weeks and from different therapeutic classes, 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);
6. If currently receiving treatment with Botox® for migraine prophylaxis and request is for concurrent use of Botox and Ajovy (i.e., not switching from one agent to another), all of the following (a, b, and c):
 - a. Sufficient evidence is provided from at least two high-quality*, published studies in reputable peer-reviewed journals or evidence-based clinical practice guidelines that provide all of the following (i – iv):

**Case studies or chart reviews are not considered high-quality evidence*

 - i. Adequate representation of the member's clinical characteristics, age, and diagnosis;
 - ii. Adequate representation of the prescribed drug regimen;
 - iii. Clinically meaningful outcomes such as a reduction in monthly migraine or headache days;

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- iv. Appropriate experimental design and method to address research questions
(see Appendix E for additional information);
- b. Member has experienced and maintained positive response to Botox monotherapy as evidenced by a $\geq 30\%$ reduction in migraine days per month from baseline following at least 2 quarterly injection (6 months) of Botox monotherapy;
- c. Despite Botox monotherapy, member continues to experience ≥ 4 migraine days per month and/or severe migraine headaches that result in disability and functional impairment;
- 7. Ajoovy is not prescribed concurrently with other injectable or oral CGRP inhibitors (e.g., Aimovig[®], Emgality[®], Vyepti[™], Nurtec[®], Qulipta[™], Ubrelvy[™]);
- 8. Dose does not exceed one of the following (a or b):
 - a. 225 mg (1 injection) once monthly;
 - b. 675 mg (3 injections) every 3 months.

Approval duration:

3 months for monthly dosing frequency

6 months for every 3 month dosing frequency

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. Migraine Prophylaxis (must meet all):

- 1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
- 2. Member has experienced and maintained positive response to therapy as evidenced by a reduction in migraine days per month from baseline;
- 3. Ajoovy is not prescribed concurrently with other injectable or oral CGRP inhibitors (e.g., Aimovig, Emgality, Vyepti, Nurtec, Qulipta, Ubrelvy);*
**This requirement does not apply to CA if member was previously approved via Centene benefit and is currently stable on therapy with both oral and injectable CGRP inhibitors*
- 4. If request is for a dose increase, new dose does not exceed one of the following (a or b):
 - a. 225 mg (1 injection) once monthly;
 - b. 675 mg (3 injections) every 3 months.

Approval duration: 6 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 6 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:

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- 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;
- B. Cluster headaches.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CGRP: calcitonin gene-related peptide

FDA: Food and Drug Administration

ICHD: International Classification of Headache Disorder

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 <i>Refer to prescribing information or Micromedex</i>	<i>Refer to prescribing information or Micromedex</i>
Beta-blockers such as: propranolol (Inderal [®]), metoprolol (Lopressor [®])*, timolol, atenolol (Tenormin [®])*, nadolol (Corgard [®])*	Migraine Prophylaxis <i>Refer to prescribing information or Micromedex</i>	<i>Refer to prescribing information or Micromedex</i>
Antidepressants/tricyclic antidepressants* such as: amitriptyline (Elavil [®]), venlafaxine (Effexor [®])	Migraine Prophylaxis <i>Refer to prescribing information or Micromedex</i>	<i>Refer to prescribing information or Micromedex</i>

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.

**Off-label use*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity
- Boxed warning(s): none reported

Appendix D: General Information

- In clinical trials, a migraine day was defined as any calendar day in which the patient reported either a headache that lasted at least 2 consecutive hours and met International Classification of Headache Disorder (ICHD)-3 diagnostic criteria for migraine (with or without aura) or probable migraine (subtype in which only 1 migraine criterion is absent), or a day when a headache of any duration was treated with migraine-specific medications (triptans or ergots).

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- The ENFORCE Phase III clinical trial program evaluating the efficacy of Ajovy in episodic and chronic cluster headache was discontinued after a pre-specified futility analysis revealed that the study's primary endpoints were unlikely to be met.

Appendix E: Appropriate Experimental Design Methods

- Randomized, prospective controlled trials are generally considered the gold standard; however:
 - In some clinical studies, it may be unnecessary or not feasible to use randomization, double-blind trials, placebos, or crossover.
 - Non-randomized prospective clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
- Case reports and chart reviews are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Migraine prophylaxis	225 mg SC once monthly or 675 mg SC every three months	675 mg every 3 months

VI. Product Availability

Single-dose prefilled syringe, autoinjector: 225 mg/1.5 mL

VII. References

1. Ajovy Prescribing Information. North Wales, PA: Teva Pharmaceuticals USA, Inc.; September 2021. Available at: www.ajovy.com. Accessed July 26, 2022.
2. Silberstein SD, Holland S, Freitag F, et al. American Academy of Neurology: Evidence-based guideline update: Pharmacologic treatment for episodic migraine prevention in adults. *Neurology* 2012; 78: 1337-45.
3. Digre KB. The American Headache Society Position Statement On Integrating New Migraine Treatments Into Clinical Practice. *Headache* 2019; 59: 1-18.
4. Ailani J, Burch RC, Robbins MS, et al. The American Headache Society Consensus Statement: Update on integrating new migraine treatments into clinical practice. *Headache*. 2021; 61: 1021-1039.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J3031	Injection, fremanezumab-vfrm, 1 mg

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.23	01.23

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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This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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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