Clinical Policy: Erenumab-aaoe (Aimovig)
Reference Number: HIM.PA.SP65
Effective Date: 10.01.20
Last Review Date: 09.20
Line of Business: HIM

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

Description
Erenumab-aaoe (Aimovig™) is a calcitonin gene-related peptide (CGRP) receptor antagonist.

FDA Approved Indication(s)
Aimovig is indicated for the preventive treatment of migraine in adults.

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that Aimovig 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. Provider’s attestation that member experiences ≥ 4 migraine days per month for at least 3 months;
      3. Age ≥ 18 years;
      4. Failure of at least 2 of the following oral migraine preventative therapies, each for 8 weeks and from different therapeutic classes, unless contraindicated or clinically significant adverse effects are experienced: antiepileptic drugs (e.g., divalproex sodium, sodium valproate, topiramate), beta-blockers (e.g., metoprolol, propranolol, timolol), antidepressants (e.g., amitriptyline, venlafaxine);
      5. Aimovig is not prescribed concurrently with Botox® or other injectable CGRP inhibitors (e.g., Ajovy™, Emgality®, Vyepti™);
      6. Dose does not exceed one of the following (a or b):
         a. 70 mg (1 injection) once monthly;
         b. 140 mg (1 injection) once monthly if medical justification is provided.
   Approval duration: 3 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): HIM.PHAR.21 for health insurance marketplace.

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 provider’s attestation of a reduction in migraine days per month from baseline;
3. Aimovig is not prescribed concurrently with Botox or other injectable CGRP inhibitors (e.g., Ajovy, Emgality);
4. If request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. 70 mg (1 injection) once monthly;
   b. 140 mg (1 injection) once monthly if medical justification is provided.

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): HIM.PHAR.21 for health insurance marketplace.

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 – HIM.PHAR.21 for health insurance marketplace.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   FDA: Food and Drug Administration
   CGRP: calcitonin gene-related peptide

   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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
</table>
| 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 |
**Appendix C: Contraindications**
- Contraindication(s): serious hypersensitivity to erenumab-aooe or to any of the excipients
- 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 experiences a qualified migraine headache (onset, continuation, or recurrence of the migraine headache). A qualified migraine headache is defined as a migraine with or without aura, lasting for ≥ 30 minutes, and meeting at least one of the following criteria (a and/or b):
  a) ≥ 2 of the following pain features: unilateral, throbbing, moderate to severe, exacerbated with exercise/physical activity;
  b) ≥ 1 of the following associated symptoms: nausea and/or vomiting, photophobia, and phonophobia.

## V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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<tbody>
<tr>
<td>Migraine prophylaxis</td>
<td>70 mg SC once monthly</td>
<td>140 mg/month</td>
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<tr>
<td></td>
<td>Some patients may benefit from a dosage of 140 mg injected subcutaneously once monthly</td>
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</tbody>
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## VI. Product Availability
Single-dose prefilled SureClick® autoinjector or prefilled syringe: 70 mg/mL, 140 mg/mL

## VII. References
Reviews, Revisions, and Approvals

| Policy created (adapted from CP.PHAR.128) per September SDC and prior clinical guidance; removed prescriber requirements; clarified provider attestation is required to confirm migraine day requirements. | 09.08.20 | 09.20 (ad hoc) |

**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.

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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.
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