Clinical Policy: Galcanezumab-gnlm (Emgality)
Reference Number: HIM.PA.SP67
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
Galcanezumab-gnlm (Emgality®) is a calcitonin gene-related peptide (CGRP) receptor antagonist.

FDA Approved Indication(s)
Emgality is indicated in adults for the:
- Preventive treatment of migraine
- Treatment of episodic cluster headache

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that Emgality 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. Emgality is not prescribed concurrently with Botox®, or other injectable CGRP inhibitors (e.g., Aimovig®, Ajovy™, Vyepii™);
   6. Dose does not exceed:
      a. Loading dose: 240 mg (2 injections) once;
      b. Maintenance dose: 120 mg (1 injection) once monthly.

Approval duration: 3 months
B. Episodic Cluster Headaches (must meet all):
   1. Diagnosis of episodic cluster headaches;
   2. Provider’s attestation that member has a history of ≥ 2 cluster periods lasting from 7 days to 1 year each and separated by ≥ 3 months;
   3. Age ≥ 18 years;
   4. Failure of verapamil at a dose of 360 mg per day, unless contraindicated or clinically significant adverse effects are experienced;
   5. Emgality is not prescribed concurrently with other injectable CGRP inhibitors (e.g., Aimovig, Ajovy);
   6. Dose does not exceed 300 mg (3 injections) once monthly.
   **Approval duration: 3 months**

C. 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. Emgality is not prescribed concurrently with Botox or other injectable CGRP inhibitors (e.g., Aimovig, Ajovy);
   4. If request is for a dose increase, new dose does not exceed 120 mg (1 injection) once monthly.
   **Approval duration: 6 months**

B. Episodic Cluster Headaches (must meet all):
   1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   2. Member is responding positively to therapy as evidenced by provider’s attestation of a reduction in cluster headache attack frequency;
   3. Provider’s attestation or pharmacy claims history to confirm that member meets one of the following (a or b):
      a. Member has not received more than 12 months of consecutive treatment;
      b. It has been at least 3 months since the member last received Emgality;
   4. Emgality is not prescribed concurrently with other injectable CGRP inhibitors (e.g., Aimovig, Ajovy);
   5. If request is for a dose increase, new dose does not exceed 300 mg (3 injections) once monthly.
   **Approval duration: 6 months (up to a total of 12 months per cluster period)**
C. 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 or evidence of coverage documents;
   B. Chronic 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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticonvulsants such as: divalproex (Depakote®), topiramate (Topamax®), valproate sodium</td>
<td><strong>Migraine Prophylaxis</strong> Refer to prescribing information or Micromedex</td>
<td>Refer to prescribing information or Micromedex</td>
</tr>
<tr>
<td>Beta-blockers such as: propranolol (Inderal®), metoprolol (Lopressor®)<em>, timolol, atenolol (Tenormin®)</em>, nadolol (Corgard®)*</td>
<td><strong>Migraine Prophylaxis</strong> Refer to prescribing information or Micromedex</td>
<td>Refer to prescribing information or Micromedex</td>
</tr>
<tr>
<td>Antidepressants/tricyclic antidepressants* such as: amitriptyline (Elavil®), venlafaxine (Effexor®)</td>
<td><strong>Migraine Prophylaxis</strong> Refer to prescribing information or Micromedex</td>
<td>Refer to prescribing information or Micromedex</td>
</tr>
<tr>
<td>verapamil*</td>
<td><strong>Episodic Cluster Headache</strong> 120 mg PO TID</td>
<td>360 mg/day</td>
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</table>

*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).
• Although Emgality given as either 120 mg SC once monthly or 240 mg SC once monthly showed a statistically significant decrease in migraine days per month compared to placebo as the primary outcome in the EVOLVE-1, EVOLVE-2, and REGAIN pivotal trials, there was no clinically significant difference between the two dosing regimens, and thus no significant additional benefit conferred from using a higher dose of Emgality. This is consistent with the FDA-approved maintenance dose of 120 mg SC once monthly.
• According to the ICHD-3 diagnostic criteria for cluster headaches, episodic cluster headaches occur in periods lasting from seven days to one year and are separated by periods of remissions that are at least 3 months. Chronic cluster headaches (affecting 10-15% of patients), on the other hand, occur for longer than a year without remission or with a remission that lasts less than 3 months. Of note, Emgality has only demonstrated efficacy in episodic cluster headaches. It failed to meet its primary endpoint in its chronic cluster headache phase 3 trial.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migraine prophylaxis</td>
<td>Loading dose: 240 mg SC once</td>
<td>120 mg/month</td>
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<tr>
<td></td>
<td>Maintenance dose: 120 mg SC once monthly</td>
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<tr>
<td>Episodic cluster headaches</td>
<td>300 mg (administered as three consecutive injections of 100 mg each) SC at the onset of the cluster period, and then monthly until the end of the cluster period</td>
<td>300 mg/month</td>
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VI. Product Availability

• Single-dose prefilled pen: 120 mg/mL
• Single-dose prefilled syringe: 100 mg/mL, 120 mg/mL

VII. References


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>Policy created (adapted from CP.PCH.24 which will be retired and split to CP.CPA.344) per September SDC and prior clinical guidance; removed redirection to Aimovig and Ajovy; removed prescriber requirements; clarified provider attestation is required to confirm migraine days and cluster headache requirements, clarified provider attestation or pharmacy claims history is required to confirm frequency of prior Emgality treatment for episodic headache.</td>
<td>09.08.20</td>
<td>09.20 (ad hoc)</td>
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**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
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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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