| Reference number(s) |
| --- |
| 391-D |

# Initial Step Therapy; Post Step Therapy Prior Authorization Triptans

## 5-HT1 Receptor Agonists (Triptans)

## Generic Step Therapy Plans (GSTP)

## Products Referenced by this Document

| Brand Name |
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| Onzetra Xsail |
| Tosymra |
| Zembrace SymTouch |

## Initial Step Therapy

If the patient has filled a prescription for at least a 30 day supply of at least one generic triptan 5-HT1 receptor agonist or at least one generic triptan 5-HT1 receptor agonist combination product within the past 730 days under a prescription benefit administered by CVS Caremark, then the requested branded drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

## Coverage Criteria

Authorization may be granted for the requested drug when ONE of the following criteria are met:

- The patient has experienced an inadequate treatment response after at least a 30 day trial of at least ONE generic triptan 5-HT1 receptor agonist OR at least ONE generic triptan 5-HT1 receptor agonist combination product.

- The patient has a documented contraindication or a potential drug interaction that would prohibit a trial of at least ONE generic triptan 5-HT1 receptor agonist OR at least ONE generic triptan 5-HT1 receptor agonist combination product.
- The patient has experienced an intolerance to at least ONE generic triptan 5-HT1 receptor agonist OR at least ONE generic triptan 5-HT1 receptor agonist combination product.
- The patient requires use of a specific dosage form (e.g., suspension, solution) that is NOT available as a generic triptan 5-HT1 receptor agonist OR a generic triptan 5-HT1 receptor agonist combination product.

# Duration of Approval (DOA)

- 391-D: DOA: 24 months

# References

N/A

# Document History

Written by: UM Development

Date Written: 04/2009

Revised: 10/2009, 07/2010, 01/2011, 05/2011, 06/2011, 02/2012 (removed Sumavel from PGST), (CY) 05/2012, (NB) 09/2012 (updated formatting and documentation & removed Maxalt), 10/2012 (removed documentation) , 03/2013 (Removed Zomig & updated grids), 05/2013 (updated question #2, removed Relpax from PGST), 05/2014 (reordered questions), 05/2015, 07/2015 (removed Axert), 04/2016 (removed Frova), 05/2016 (added Onzetra and Zembrace), 01/2017 (removed Relpax), (SF) 06/2017 (added Onzetra, Treximet & Zembrace to PGST, add Relpax to all 3 versions), 01/2018 (added Sumavel to PGST), 06/2018 (removed all targeted products in PGST, removed Alsuma, Relpax, Sumavel, Treximet from HPGST & TGST), 06/2019 (no changes), 06/2020 (no changes); (CJH) 06/2021 (no clinical changes), (DFW) 06/2022 (no clinical changes), (DFW/KEJ) 05/2023 (added Tosymra to all programs); (DFW) 05/2024 (no clinical changes); (KEJ) 11/2024 (updated look back to 730 days, retired 390-D and 410-D)

Reviewed: Medical Affairs 05/2009, 10/2009, 07/2010, 01/2011, 06/2011, 02/2012, 05/2012; (DC) 09/2012, (LS) 03/2013, (LB) 05/2013, (DC) 05/2014, (DC) 05/2015, (LS) 05/2016; (ABM) 06/2017, 02/2018; (CHART) 06/25/2020, 07/01/2021, 06/30/2022, 06/01/2023 (annual review), 06/15/2023 (updates to annual review), 05/30/2024, 12/05/2024

External Review: 05/2009, 12/2009, 04/2010, 10/2010, 10/2011, 10/2012, 10/2013, 10/2014, 10/2015, 10/2016, 10/2017, 02/2018, 10/2018, 10/2019, 10/2020, 10/2021, 10/2022, 08/2023, 10/2024, 12/2024 (FYI)

**CRITERIA FOR APPROVAL**

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| 1 | Has the patient experienced an inadequate treatment response after at least a 30 day trial of at least one generic triptan 5-HT1 receptor agonist or at least one generic triptan 5-HT1 receptor agonist combination product?<br>[If Yes, then no further questions. If No, then go to 2.] | Yes | No |
| 2 | Does the patient have a documented contraindication or a potential drug interaction that would prohibit a trial of at least one generic triptan 5-HT1 receptor agonist or at least one generic triptan 5-HT1 receptor agonist combination product?<br>[If Yes, then no further questions. If No, then go to 3.] | Yes | No |
| 3 | Has the patient experienced an intolerance to at least one generic triptan 5-HT1 receptor agonist or at least one generic triptan 5-HT1 receptor agonist combination product?<br>[If Yes, then no further questions. If No, then go to 4.] | Yes | No |
| 4 | Does the patient require use of a specific dosage form (e.g., suspension, solution) that is not available as a generic triptan 5-HT1 receptor agonist or a generic triptan 5-HT1 receptor agonist combination product?<br>[No further questions] | Yes | No |

| Mapping Instructions | | | |
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| | **Yes** | **No** | **DENIAL REASONS** |
| **1.** | Approve, 24 Months | Go to 2 | |
| **2.** | Approve, 24 Months | Go to 3 | |
| **3.** | Approve, 24 Months | Go to 4 | |
| **4.** | Approve, 24 Months | Deny | Your plan only covers this drug if you have tried at least one generic triptan or at least one generic triptan combination product and it did not work well for you. We have denied your request because: A) You have not tried it, and B) You do not have a medical |

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| | | | reason not to take it. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.<br><br>[Short Description: Step Therapy] |