Clinical Policy: Galcanezumab-gnlm (Emgality)

Reference Number: CP.CPA.344
Effective Date: 03.01.20
Last Review Date: 02.21
Line of Business: Commercial

Revision Log

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 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);
5. Emgality is not prescribed concurrently with Botox® or other injectable and oral CGRP inhibitors (e.g., Aimovig®, Ajovy®, Vyepti™, Nurtec®, Ubrelvy™);
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 and oral CGRP inhibitors (e.g., Aimovig, Ajovy, Vyepti, Nurtec, Ubrelvy);
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): CP.CPA.09 for commercial.

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 and oral CGRP inhibitors (e.g., Aimovig, Ajovy, Vyepti, Nurtec, 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 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 and oral CGRP inhibitors (e.g., Aimovig, Ajovy, Vyepti, Nurtec, 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*
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): CP.CPA.09 for commercial.

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 – CP.CPA.09 for commercial 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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
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*
Antidepressants/tricyclic antidepressants* such as: amitriptyline (Elavil®), venlafaxine (Effexor®)	**Migraine Prophylaxis** *Refer to prescribing information or Micromedex*	*Refer to prescribing information or Micromedex*
verapamil*	**Episodic Cluster Headache** 120 mg PO TID	360 mg/day

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

Indication	Dosing Regimen	Maximum Dose
Migraine prophylaxis	Loading dose: 240 mg SC once Maintenance dose: 120 mg SC once monthly	120 mg/month
Episodic cluster headaches	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	300 mg/month

VI. Product Availability

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

VII. References

1. Emgality Prescribing Information. Indianapolis, IN: Eli Lilly and Company; December 2019. Available at: http://www.emgality.com. Accessed November 18, 2020.
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. Stauffer VL, Dodick DW, Zhang Q, et al. Evaluation of galcanezumab for the prevention of episodic migraine: the EVOLVE-1 randomized clinical trial. JAMA Neurol. 2018; 75(9):1080-1088.
4. Skljarevski V, Matharu M, Millen BA, et al. Efficacy and safety of galcanezumab for the prevention of episodic migraine: results of the EVOLVE-2 phase 3 randomized controlled clinical trial. Cephalalgia. 2018; 38(8):1442-1454.

5. Detke H, Wang S, Skljarevski V, et al A phase 3, randomized, double-blind, placebo-controlled study of LY2951742 in patients with chronic migraine – the REGAIN study. Poster session presented at: International Headache Congress; Sept 7-10, 2017; Vancouver, Canada.
6. Headache Classification Committee of the International Headache Society. The International classification of headache disorders, 3rd edition (beta version). Cephalalgia. 2013; 33(9): 629-808.
7. Francis BJ, Becker WJ, and Pringsheim TM. Acute and preventative pharmacologic treatment of cluster headache. Neurology. 2010; 75: 463-473.
8. Robbins MS, Starling AJ, Pringsheim TM, Becker WJ, and Schwedt TJ. Treatment of cluster headache: The American Headache Society evidence-based guidelines. Headache. 2016; 56: 1093-1106.
9. Digre KB. The American Headache Society Position Statement On Integrating New Migraine Treatments Into Clinical Practice. Headache 2019; 59: 1-18.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created (adapted from CP.PHAR.404); added redirection to Aimovig and Ajovy for migraine prophylaxis indication per SDC and prior clinical guidance.	12.02.19	02.20
1Q 2020 annual review: for episodic cluster headache removed "≥ 1 cluster headache attack every other day and ≤ 8 cluster headache attacks per day with a total of ≥ 5 previous attacks", added lower limit of 7 days for cluster period consistent with ICHD-3 diagnostic criteria; references reviewed and updated.	12.03.19	02.20
Added Ajovy to Appendix B.	04.24.20	
CP.PCH.24 retired; CP.CPA.344 unretired per September SDC and prior clinical guidance.	09.10.20	09.20 (ad hoc)
Per October 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.	10.07.20	
1Q 2021 annual review: no significant changes; references reviewed and updated.	11.18.20	02.21
Revised requirement on concurrent use with other CGRP inhibitors to include oral products with Nurtec and Ubrelvy listed as additional examples; added clarification in continuation of therapy to indicate requirement for concurrent use with other CGRP inhibitors 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.	06.28.21	

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.

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