DRUG QUANTITY MANAGEMENT POLICY – PER DAYS

POLICY: Calcitonin Gene-Related Peptide Inhibitors – Aimovig Drug Quantity Management Policy – Per Days
- Aimovig® (erenumab-aooe subcutaneous injection – Amgen)

REVIEW DATE: 04/30/2024

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Aimovig, a calcitonin gene-related peptide (CGRP) receptor antagonist, is indicated for the **preventive treatment of migraine** in adults.[1]

Dosing

The recommended dose of Aimovig is 70 mg injected subcutaneously (SC) once monthly.[1] Some patients may benefit from a dose of 140 mg SC once monthly. If a dose of Aimovig is missed, administer as soon as possible. Thereafter, Aimovig can be scheduled monthly from the date of the last dose.

Availability

Aimovig is available as 70 mg/mL and 140 mg/mL single-dose prefilled auto-injectors.[1] Aimovig is also approved to be supplied as 70 mg/mL and 140 mg/mL single-dose prefilled syringes; however, the prefilled syringes are not currently available.

POLICY STATEMENT

This Drug Quantity Management program has been developed to manage potential dose escalation of Aimovig. If the Drug Quantity Management rule is not met for the requested medication at the point of service, coverage will be determined by the Criteria below. All approvals are provided for the duration noted below.

Drug Quantity Limits

Product	Strength and Form	Retail Maximum Quantity per 30 Days	Home Delivery Maximum Quantity per 90 Days
Aimovig® (erenumab-aooe subcutaneous injection)	70 mg/mL prefilled auto-injectors	1 auto-injector (1 mL)	3 auto-injectors (3 mL)
	140 mg/mL prefilled auto-injectors	1 auto-injector (1 mL)	3 auto-injectors (3 mL)

Calcitonin Gene-Related Peptide Inhibitors – Aimovig Drug Quantity Management Policy – Per Days product(s) is(are) covered as medically necessary when the following criteria is(are) met. Any other exception is considered not medically necessary.

CRITERIA

Aimovig 70 mg/mL prefilled auto-injectors

1. If the patient requires a dose titration from 70 mg once monthly to 140 mg once monthly, approve a one-time override for one 70 mg/mL prefilled syringe or auto-injector at retail or home delivery.
Note: In other situations where the patient is changing to a 140 mg once monthly dose, the 140 mg/mL auto-injector should be used.

Aimovig 140 mg/mL prefilled auto-injector/syringes

No overrides recommended.

REFERENCES

1. Aimovig® subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; October 2022.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	04/24/2023
Annual Revision	No criteria changes.	04/30/2024