

## CARE VALUE POLICY

**POLICY:** Migraine – Ubrelvy Care Value Policy

- Ubrelvy™ (ubrogepant tablet – Allergan)

**REVIEW DATE:** 06/09/2021

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### OVERVIEW

Ubrelvy, a calcitonin gene-related peptide receptor antagonist, is indicated for the **acute treatment of migraine headache** with or without aura in adults.<sup>1</sup> Limitations of Use: Ubrelvy is not indicated for the preventive treatment of migraine.

The recommended dose of Ubrelvy is 50 mg or 100 mg taken orally with or without food.<sup>1</sup> If needed, a second dose may be taken  $\geq 2$  hours after the initial dose. The maximum dose in a 24-hour period is 200 mg. The safety of treating more than 8 migraines in a 30-day period has not been established.

### Guidelines

Triptans (e.g., almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, sumatriptan, and zolmitriptan) are considered the gold standard for acute treatment of moderate to severe migraine headaches or mild to moderate migraine headaches that respond poorly to over-the-counter analgesics.<sup>2</sup> An updated assessment of the **preventive and acute treatment of migraine by the American Headache Society (2018)** lists the triptans and dihydroergotamine as effective treatments for moderate or severe acute migraine attacks and mild to moderate attacks that respond poorly to nonsteroidal anti-inflammatory drugs (NSAIDs) or caffeinated combinations (e.g., aspirin + acetaminophen + caffeine).<sup>3</sup> Treat at the first sign of pain to improve the probability of achieving freedom from pain and reduce attack-related disability.

### POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Ubrelvy. All approvals are provided for the duration noted below.

**Automation:** None.

### RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Ubrelvy is recommended in those who meet the following criteria:

#### FDA-Approved Indications

- 1. Migraine, Acute Treatment.** Approve for 1 year if the patient meets the following criteria (A and B):
  - A)** Patient is  $\geq 18$  years of age; AND
  - B)** Patient meets ONE of the following (i or ii):
    - i.** Patient has tried at least one triptan therapy; OR
    - ii.** Patient has a contraindication to triptan(s) according to the prescriber.

**CONDITIONS NOT RECOMMENDED FOR APPROVAL**

Coverage of Ubrely is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

**REFERENCES**

1. Ubrely™ tablets [prescribing information]. Madison, NJ: Allergan; December 2019.
2. MacGregor EA. In the clinic. Migraine. *Ann Intern Med.* 2017;166(7):ITC49-ITC64.
3. American Headache Society. The American Headache Society position statement on integrating new migraine treatments into clinical practice. *Headache.* 2019;59:1-18.

**HISTORY**

Type of Revision	Summary of Changes	Review Date
New Policy	--	06/03/2020
Annual Revision	No criteria changes.	06/09/2021