

Title: sumatriptan succinate (Imitrex) Injection

Origination: 03/14/06	Revised: 10/21/09	Annual Review: 12/15/11
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Purpose:

To provide guidelines and criteria for the review and decision determination of requests for medications that requires prior authorization.

Background Information:

Medication Summary

- Imitrex (sumatriptan) injection is a 5-hydroxytryptamine₁ (5HT₁) receptor subtype agonist, which binds selectively to the receptor thereby exerting an antimigrainous effect. Imitrex injection is indicated for the acute treatment of migraine attacks with or without aura. Imitrex injection is also indicated for the acute treatment of cluster headache episodes.

Eligibility Criteria

- Member must be eligible and have applicable benefits.
- Member must be over 18 years of age.
- Prior authorization requests that do not meet clinical criteria in this Procedure will be forwarded to a Clinical Pharmacist for review.

Exclusions

- Member with history, signs, or symptoms of ischemic cardiac syndromes (including but not limited to, angina pectoris of any type, all forms of myocardial infarction, and silent myocardial ischemia), cerebrovascular syndromes (including but not limited to, strokes of any kind and transient ischemic attacks), peripheral vascular symptoms (including but not limited to, ischemic bowel disease), or other significant underlying cardiovascular diseases.
- Member less than 18 years of age.
- Member with uncontrolled hypertension.
- Concomitant use with other ergotamine-containing or ergotamine-like medications or other 5HT₁ agonist within 24 hours of each other.
- Concomitant use of monoamine oxidase inhibitors (MAOIs) including, but not limited to: isocarboxazid, phenelzine, tranylcypromine.
- Member with hemiplegic or basilar migraine.
- Member with severe hepatic impairment.
- Member with hypersensitivity to Imitrex or any of its components.

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Background Information, continued:

Reference Statement

- Guidelines will be compiled from available US Food and Drug Administration (FDA) approved indications, general practice guidelines, and/or evidence-based uses established through phase III clinical studies without published conflicting data. Only clinical studies published in their entirety in reputable peer-reviewed journals will be evaluated.

Procedure:

- 1.0 Request for the *initial therapy* for **migraine headache or cluster headache** requires documentation from the Member's medical records maintained by the requesting provider verifying the following:
 - 1.1 Diagnosis of Migraine headaches or Cluster headaches, **AND**
 - 1.2 Migraine not controlled with oral migraine medications or prophylactic therapy, **OR**
 - 1.2 Member cannot tolerate oral migraine medications, **OR**
 - 1.2 Injection needed due to Member experiencing nausea/vomiting associated with migraine attacks.
- 2.0 If criteria have been met, initial therapy may be approved for a maximum of six (6) injections per month for a maximum of one (1) year.
- 3.0 Request for *continuation of therapy* beyond initial authorization period requires documentation from the Member's medical records maintained by the requesting independent practitioner verifying the Member is not experiencing any severe adverse reactions:
 - 3.1 If criterion is met, continuation of therapy may be approved for a maximum of six (6) injections per month for a maximum of one (1) year.

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References:

1. GlaxoSmithKline. Imitrex[®] (sumatriptan succinate) Solution for Injection. Prescribing Information. Revised April 2007.
2. Evers, S, Afra, J, Frese, A, Goadsby, PJ, Linde, M, May, A, Sandor, PS. *EFNS Guidelines on the drug treatment of migraine*. Eur J Neurol. 2006 Jun;13(6):560-72.
3. Landy S, Smith T. Treatment of primary headache: acute migraine treatment. In: Standards of care for headache diagnosis and treatment. Chicago (IL): National Headache Foundation; 2004. p. 27-39.
4. Medical Letter. Drugs for Migraine, Treatment Guidelines. New Rochelle, NY. 2008 March; 6(67): 17-22. <http://www.medletter.com/downloads/t67.pdf>. Accessed October 8, 2009.
5. Biondi D, Mendes P. Treatment of primary headache: cluster headache. In: Standards of care for headache diagnosis and treatment. Chicago (IL): National Headache Foundation; 2004. p. 59-72.

Disclaimer Information:

Prior Authorization criteria are developed to determine coverage for AvMed Health Plans' benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed Health Plans makes coverage decisions based on the Member's benefit plan contract and these criteria. This guideline sets forth concise clinical coverage criteria which have been developed from a review of current literature, policies of the FDA and other government agencies, and other appropriate references, in consultation and with approval from practicing physicians who are members of AvMed's Pharmacy and Therapeutic committee. Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change. The use of these criteria is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.