Drug Coverage Policy

Effective Date.....10/1/2025
Coverage Policy Number.....IP0114
Policy Title.....Reyvow

Migraine – Reyvow

- Reyvow® (lasmiditan tablets – Lilly)

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 where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. 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.

OVERVIEW

Reyvow, a serotonin subtype 1F receptor agonist, is indicated for the **acute treatment of migraine** with or without aura in adults.[1] Limitations of Use: Reyvow is not indicated for the preventive treatment of migraine.

Disease Overview
Migraine is a common, ongoing condition marked by paroxysmal, unilateral attacks of moderate to severe throbbing headache which are aggravated by routine physical activity (e.g., walking or climbing stairs) and associated with nausea, vomiting, and/or photophobia and phonophobia.[2] Migraines have been defined as chronic or episodic. Chronic migraine is described by the International Headache Society as headache occurring on ≥ 15 days/month for more than 3 months, which has the features of migraine headache on ≥ 8 days/month. Episodic migraine is characterized by headaches that occur < 15 days/month.[3]

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. An assessment of the preventive and acute treatment of migraine by the American Headache Society (2018; updated 2021) reaffirms previous migraine guidelines.[4,5] The update lists the triptans, dihydroergotamine, the oral gepants (Nurtec® ODT [rimegepant orally disintegrating tablets,] and Ubrelvy® [ubrogepant tablets]), and Reyvow as effective treatments for moderate or severe acute migraine attacks and mild to moderate attacks that respond poorly to nonsteroidal anti-inflammatory drugs, non-opioid analgesics, acetaminophen, or caffeinated combinations (e.g., aspirin + acetaminophen + caffeine). The recommendation remains that clinicians must consider medication efficacy and potential medication-related adverse events when prescribing acute medications for migraine.

Coverage Policy

Policy Statement
Prior Authorization is required for benefit coverage of Reyvow. All approvals are provided for the duration noted below.

Reyvow is considered medically necessary when the following are met:

FDA-Approved Indication

1. **Migraine, Acute Treatment.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Preferred product Criteria is met for the product(s) as listed in the below table(s)

Employer Plans:

Product	Criteria
Reyvow (lasmiditan tablets)	**Standard/Performance Drug List Plans:** The patient meets **ONE** of the following (A or B): A. Patient meets one of the following (i or ii): i. The patient has tried at least **ONE** triptan product (for example, almotriptan [Axert, generics], eletriptan [Relpax, generics], frovatriptan [Frova, generics], naratriptan [Amerge, generics], rizatriptan [Maxalt, generics],

Product	Criteria
	sumatriptan [Imitrex, generics], zolmitriptan [Zomig, generics]); OR ii. The patient has tried and experienced inadequate efficacy or significant intolerance to one triptan/non-steroidal anti-inflammatory drug (NSAID) combination product (e.g., Treximet or Symbravo) OR the patient has tried and experienced inadequate efficacy or significant intolerance to a triptan taken concomitantly with an NSAID; OR B. Patient meets one of the following (i or ii): i. Per the prescriber, the patient has a contraindication to triptans; OR ii. Per the prescriber, the patient has had a significant intolerance to one or more triptans. Note: Examples of contraindications to triptans include a history of coronary artery disease; cardiac accessory conduction pathway disorders; history of stroke, transient ischemic attack, or hemiplegic or basilar migraine; peripheral vascular disease; ischemic bowel disease; uncontrolled hypertension; or severe hepatic impairment. **Value/Advantage/Total Savings/Legacy Drug List Plans:** The patient meets BOTH of the following (A and B): A. Patient meets one of the following (i or ii): i. The patient has tried and experienced inadequate efficacy or significant intolerance to BOTH Nurtec ODT AND Ubrelvy ii. If the patient is unable to swallow or has difficulty swallowing tablets, the patient has tried and experienced inadequate efficacy or significant intolerance to Nurtec ODT; AND Note: The patient would still need to meet criteria B even if criteria A is met. B. Patient meets one of the following (i or ii): i. Patient meets one of the following (1 or 2): 1. The patient has tried and experienced inadequate efficacy or significant intolerance to **TWO** triptan products (for example, almotriptan [Axert, generics], eletriptan [Relpax, generics], frovatriptan [Frova, generics], naratriptan [Amerge, generics], rizatriptan [Maxalt, generics], sumatriptan [Imitrex, generics], zolmitriptan [Zomig, generics]); OR 2. The patient has tried and experienced inadequate efficacy or significant intolerance to one triptan/non-steroidal anti-inflammatory drug (NSAID) combination product (e.g., Treximet or Symbravo) OR the patient has tried and experienced inadequate efficacy or significant intolerance to a triptan taken concomitantly with an NSAID; OR ii. Patient meets one of the following (1 or 2): 1. Per the prescriber, the patient has a contraindication to triptans; OR 2. Per the prescriber, the patient has had a significant intolerance to one or more triptans.

Product	Criteria
	Note: Examples of contraindications to triptans include a history of coronary artery disease; cardiac accessory conduction pathway disorders; history of stroke, transient ischemic attack, or hemiplegic or basilar migraine; peripheral vascular disease; ischemic bowel disease; uncontrolled hypertension; or severe hepatic impairment.

Individual and Family Plans:

Product	Criteria
Reyvow (lasmiditan tablets)	The patient meets one of the following (A or B): A. Patient meets one of the following (i or ii): i. The patient has tried and experienced inadequate efficacy or significant intolerance to **TWO** triptan products (for example, almotriptan [Axert, generics], eletriptan [Relpax, generics], frovatriptan [Frova, generics], naratriptan [Amerge, generics], rizatriptan [Maxalt, generics], sumatriptan [Imitrex, generics], zolmitriptan [Zomig, generics]); OR ii. The patient has tried and experienced inadequate efficacy or significant intolerance to one triptan/non-steroidal anti-inflammatory drug (NSAID) combination product (e.g., Treximet or Symbravo) [may require prior authorization] OR the patient has tried and experienced inadequate efficacy or significant intolerance to a triptan taken concomitantly with an NSAID; OR B. Patient meets one of the following (i or ii): i. Per the prescriber, the patient has a contraindication to triptans; OR ii. Per the prescriber, the patient has had a significant intolerance to one or more triptans. Note: Examples of contraindications to triptans include a history of coronary artery disease; cardiac accessory conduction pathway disorders; history of stroke, transient ischemic attack, or hemiplegic or basilar migraine; peripheral vascular disease; ischemic bowel disease; uncontrolled hypertension; or severe hepatic impairment.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Reyvow for any other use is considered not medically necessary. Criteria will be updated as new published data are available.

References

1. Reyvow® tablets [prescribing information]. Indianapolis, IN: Lilly; September 2022.
2. Headache Classification Subcommittee of the International Headache Society. The International Classification of Headache Disorders: 3rd edition. *Cephalalgia*. 2018;38(1):1-211.
3. Lipton RB, Silberstein SD. Episodic and chronic migraine headache: breaking down barriers to optimal treatment and prevention. *Headache*. 2015;52:103-122.
4. American Headache Society. The American Headache Society position statement on integrating new migraine treatments into clinical practice. *Headache*. 2019;59:1-18.
5. Ailani J, Burch RC, Robbins MS, on behalf of the Board of Directors of the American Headache Society. The American Headache Society Consensus Statement: Update on integrating new migraine treatments into clinical practice. *Headache*. 2021;61(7):1021-1039.

Revision Details

Type of Revision	Summary of Changes	Date
Selected Revision	**Updated** review date, disclaimer, refreshed background, and references added change history.	12/15/2024
Selected Revision	**Updated** coverage policy title from L*asmiditan* to *Migraine – Reyvow*. **Relocated** the triptan prerequisite requirements to preferred product boxes. **Added** steps through Nurtec ODT and Ubrelvy to the Value/Advantage, Total Savings and Legacy Drug List Plans.	7/1/2025
Selected Revision	**Employer Plans and Individual and Family Plans Preferred Product Criteria Tables.** **Added "**The patient has tried and experienced inadequate efficacy or significant intolerance to one triptan/non-steroidal anti-inflammatory drug (NSAID) combination product OR the patient has tried and experienced inadequate efficacy or significant intolerance to a triptan taken concomitantly with an NSAID" exception criteria.	9/1/2025
Annual Revision	No criteria changes.	10/1/2025

The policy effective date is in force until updated or retired.

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