Atogepant (QULIPTA) for Episodic Migraine Prevention
Criteria for Use
July 2025

VA Pharmacy Benefits Management Services and National Formulary Committee

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. THE CLINICIAN SHOULD USE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT. INDIVIDUAL CASES THAT ARE EXCEPTIONS TO THE EXCLUSION AND INCLUSION CRITERIA SHOULD BE ADJUDICATED AT THE LOCAL FACILITY ACCORDING TO THE POLICY AND PROCEDURES OF ITS P&T COMMITTEE AND PHARMACY SERVICES.

The Product Information should be consulted for detailed prescribing information.

Exclusion Criteria

If the answer to ANY item below is met, then the patient should NOT receive atogepant.

- ☐ Severe hepatic impairment (Child-Pugh C)
- ☐ Patient has uncontrolled hypertension
- ☐ Patient has a history of Raynaud's phenomenon with ischemia (e.g., history of digital ulcers, tissue necrosis, or other critical ischemia)[1]
- ☐ Concurrent preventive therapy with another calcitonin gene related peptide (CGRP) targeting agent (including other gepants and CGRP targeting monoclonal antibodies)
- ☐ Pregnancy

Inclusion Criteria

The answers to all of the following must be fulfilled in order to meet criteria.

- ☐ A comprehensive headache appointment has been completed prior to initiation[2,3]
- ☐ Episodic migraine defined as 4 to 14 monthly migraine days
- ☐ Moderate to severe migraine intensity
- ☐ Contraindication, intolerance, or lack of therapeutic response after at least 12 weeks each of a therapeutic dose of at least 3 of the following: beta blocker, topiramate, divalproex, SNRI or TCA, and ACE inhibitor or ARB[4]
- ☐ Contraindication, intolerance, or lack of therapeutic response after at least 12 weeks of a therapeutic dose of at least one CGRP-targeted monoclonal antibody (e.g., erenumab)[5]

Footnotes:

[1] Atogepant should be discontinued if signs or symptoms of Raynaud's phenomenon develop. All patients with a history of Raynaud's phenomenon should be monitored for and informed about the possibility of recurrence and worsening.

[2] A locally designated headache expert should be performing a comprehensive headache assessment including evaluation for medication overuse headache, other secondary headache types, adherence to prior headache therapies, and features that require urgent/emergent evaluation. Also, the patient's headache history should be reviewed to identify triggers, effective acute treatment, and nonpharmacologic interventions. A board certification in headache medicine is not required to meet this criterion.

[3] Patients started on atogepant must have a scheduled blood pressure check 2-4 weeks after initiation of therapy

[4] SNRI: Serotonin Norepinephrine Reuptake Inhibitor; TCA: Tricyclic Antidepressant; ACE: Angiotensin-Converting Enzyme; ARB: Angiotensin II Receptor Blocker. Therapeutic doses for oral preventive agents are as follows: beta blocker (e.g., metoprolol 50-100 mg BID, propranolol 20-80 mg BID), topiramate 50-200 mg BID, divalproex 500-1000 mg daily, ACE inhibitor or ARB (e.g., lisinopril 20 mg daily, enalapril 10 mg daily, telmisartan 80 mg daily), SNRI or TCA (e.g., venlafaxine SA 75-150 mg daily, amitriptyline 25-100 mg daily). Divalproex is not recommended in patients who can become pregnant.
[5] Erenumab-aooe is the national contract agent and PA-F. If patient displays failure or intolerance to erenumab, an alternate non-formulary CGRP-targeted monoclonal antibody (e.g., fremanezumab, galcanezumab, eptinezumab) should be tried.

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