

FROVA®  
UTILIZATION MANAGEMENT CRITERIA

**DRUG CLASS:** 5HT1 agonists  
**BRAND (generic) NAME:** Frova (frovatriptan) tablet 2.5 mg tablet

**FDA INDICATIONS:**

Oral frovatriptan is indicated for the acute treatment of migraine with or without aura in adults. The 5-HT1 agonists are not intended for the prophylactic therapy of migraine or for use in the management of hemiplegic or basilar migraine. Safety and effectiveness have also not been established for cluster headache.

**ICD-9 CODE:** Migraine – with aura (“classic”): 346.0  
Migraine – idiopathic/without aura (“common”): 346.1

**QUANTITY LIMITATIONS (QL) CRITERIA:**

	<b>SHORT TERM:</b>	<b>EXTENDED SUPPLY:</b>
	30 mg per 30 days	90 mg per 90 days
Frova 2.5 mg	12 tablets	36 tablets

**RATIONALE:** Frova (frovatriptan) tablets - Frovatriptan has a maximum dose of 7.5 mg per day. Elan has studied frovatriptan in up to 4 migraines per month, or 30 mg per month.

**CRITERIA FOR EXCEEDING QL:**

1. Convey to physician the amount of the drug that the patient has already received (refer to QL criteria) and ask if the patient needs more than that amount. **AND**
2. Patient must have diagnosis of moderate to severe migraine headache. (Tension type and chronic daily headaches are **NOT** appropriate diagnoses.) **AND**
3. Must have tried and failed at least 2 other abortive migraine therapies. Examples of medications used for abortive therapy include:
  - Ibuprofen (Motrin®) • Diclofenac (Voltaren®)
  - Isometheptene mucate/Dichloralphenazone/Acetaminophen (Midrin, etc.)
  - Flurbiprofen (Ansaid®) • Ergotamine – containing products (Cafergot, Wigraine, Ergomar, etc.) **AND**
4. If patient experiences >4 migraine headaches per month, prophylactic therapy has been given an adequate trial (see Table below). **AND**
5. The possibility of medication-induced, rebound, or chronic daily headache should be considered. **AND**
6. **DENY** if to be used in combination with another triptan (e.g., Zomig, Amerge, Axert, Imitrex, Maxalt, Relpax) or an ergotamine (e.g., Migranal, Cafergot) due to possibility of increased blood pressure effect.

**BLACK BOX WARNINGS:**

None

**RATIONALE:**

- Aspirin, acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs) and combination products containing these key ingredients are generally considered first line abortive therapy for migraine.
- Prophylactic migraine therapy may reduce the frequency and severity of migraine attacks.
- Quantity limitations criteria are intended to prevent inappropriate use of the triptans.

**NURSING ASSESSMENT:**

1. Gather a complete medical history; note any contributing factors (i.e., smoker, diet, alcohol consumption, use of OTC medications, stress, etc.). Include migraine history and any precipitating factors.
2. Determine any history of cardiac problems or evidence of ischemic cardiovascular disease, as drug is contraindicated.
3. Ensure that a neurological examination has been performed to identify appropriate migraine category.
4. Obtain baseline ECG, liver (AST, ALT), and renal function tests.

**PROVIDER EDUCATION:**

1. Review appropriate method for administration (oral).
2. Dizziness, paresthesia, headache, dry mouth, fatigue, and flushing are the most common adverse effects.
3. Endo Pharmaceuticals: 866-395-8301.

**MISUSE AND CHRONIC DAILY HEADACHE:**

Chronic Daily Headache (CDH) is a syndrome that consists of a group of disorders that can be subclassified into primary and secondary types. Drug-induced daily headache frequently arises during headache therapy. It can result from the daily use of ergotamines and excessive amounts of common analgesics. CDH usually manifests itself as a constant dull pressure in the frontal and occipital areas. Most patients will complain of headache upon awakening in the morning. The symptomatic medications used for the immediate relief of headache may actually perpetuate the headache if used frequently and in excessive quantities. Therapy for drug-induced headache is withdrawal of the responsible medication.

**CLINICAL OUTCOME:**

Reversal of acute migraine attack and relief of associated symptoms

**DOSAGE AND ADMINISTRATION:**

The frovatriptan dose for the treatment of acute migraine in adults is 2.5 mg. A second dose may be taken no sooner than 2 hours after the initial dose. Subsequent doses should be separated by not less than 2 hours. The total daily dose should not exceed 7.5 mg. There is no evidence that a second dose of frovatriptan is effective in patients who do not respond to a first dose of the drug for the same headache. The safety of using frovatriptan to treat more than 4 migraine headaches in a 30-day period has not been established. NOTE: In patients who do not respond to the first dose of frovatriptan, the diagnosis of migraine should be reconsidered before administration of a second dose and the possibility of an evolving cerebrovascular event considered.

**RISK FACTORS/CONTRAINDICATIONS:**

1. Do not use with ergotamine-containing products or MAO-A inhibitors.

2. Do not use with patients with ischemic heart disease or uncontrolled blood pressure.
3. Do not use as a prophylactic agent.
4. Give only where diagnosis of migraine is clearly established.
5. Contraindications to the use of 5-HT<sub>1</sub> agonists: pregnancy, peripheral vascular disease (i.e., thromboangitis, leucic arteritis, Raynaud's Syndrome, thrombophlebitis, arteriosclerosis), hepatic or renal impairment, coronary artery disease, uncontrolled hypertension.

**DRUG INTERACTIONS:**

Ergot-containing drugs have been reported to cause prolonged vasospastic reactions. Because there is a theoretical basis that these effects may be additive, use of ergotamine-containing or ergot-type medications (like dihydroergotamine) and 5-HT<sub>1</sub> agonists within 24 hours of each other should be avoided.

- MAO-A inhibitors increase the systemic exposure of the 5-HT<sub>1</sub> agonists and concomitant use is contraindicated.
- Concomitant use of more than one 5-HT<sub>1</sub> agonist within 24 hours of each other is not recommended.
- Selective serotonin reuptake inhibitors (SSRIs) have been reported to cause weakness, hyperreflexia, and in coordination when coadministered with 5-HT<sub>1</sub> agonists.

**Migraine therapy options:**

Prophylactic therapy for migraine headache:

<b>DRUG CLASS</b>	<b>NAME</b>
• Beta Blockers	Propranolol Atenolol Metoprolol Timolol
• Antidepressants	Amitriptyline Fluoxetine
• Calcium Channel Blockers	Nifedipine Verapamil Diltiazem
• Anticonvulsants	Divalproex sodium/sodium valproate Carbamazepine Gabapentin Topiramate
• NSAIDs	Naproxen Aspirin Ketoprofen
• Other	Feverfew Magnesium Vitamin B2 (Riboflavin)

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**REFERENCES:**

1. Frova (frovatriptan) product information. Endo Pharmaceuticals, Inc. April 2007

2. Snow V, Weiss K, Wall EM et al. Pharmacologic Management of Acute Attacks of Migraine and Prevention of Migraine Headache. *Annals of Internal Med.* 2002;137(10):840-849.
3. Silberstein SD et al. "Practice Parameter: Evidence based guidelines for migraine headache (an evidence-based review). Report on the Quality Standards Subcommittee of the American Academy of Neurology." *Neurology* 2000;55:754-63.
4. Seema M and Lowder DM. Medications for Migraine Prophylaxis. *Am Fam Physician* 2006;73:72-8.
5. Edmeads JG, Gawel MJ, Vickers J. Strategies for diagnosing and managing medication-induced headache. *Can Fam Physician.* 1997; 43: 1249-1254.
6. Mathew NT. Transformed migraine, analgesic rebound, and other chronic daily headaches. *Neurologic Clinics.* 1997; 15 (1): 167-186.
7. Weitzel KW, Thomas ML, Small R, Goode VG. Migraine: a comprehensive review of new treatment options. *Pharmacotherapy* 2000; 19: 957-973.
8. Tfelt-Hansen P, DeVries P, Saxena P. Triptans in migraine: a comparative review of pharmacology, pharmacokinetics and efficacy. *Drugs* 2000; 60: 1259-1287.
9. Easthope SE, Goa KL. Frovatriptan. *CNS Drugs* 2001; 15: 969-78.
11. Ryan R, Geraud G, Goldstein J, Cady R, Keywood C. Clinical efficacy of frovatriptan: Placebo-controlled studies. *Headache* 2002; 42 (suppl 2): S84-S92.

### References supporting average number of migraine attacks per month:

12. Solomon GD, et al. *Neurology* 1997; 49: 1219-25 (n=327) study ~3 +/- 1.37 per month.
13. Zagami AS, et al *Neurology* 1997; 48 (suppl 3): S25-8 (n=2,058) and Geraud GEA.
14. *Eur Neurol* 1996; 32 (suppl 2): 24-7 (n=606) ~2.9-3.2 per month.
15. Fletcher PE, et al. *Headache Treatment: Trial Methodology and New Drugs.* Lippincott-Raven. Publishers, 1997 (n=701) ~2.9 to 3.2 per month.
16. Visser WH, et al. *Neurology* 1996; 46: 522-6 (n=84) ~ 3-4 per month.
17. Dowson A. *Eur Neurol* 1996; 36 (suppl 2): 28-31 (n=40) ~ 2 per month.

### General References:

18. Beckett B. Headache disorder, in Dipiro J (ed): *Pharmacotherapy: a pathophysiologic approach.* Stamford, Simon & Schuster, 1997; pp1279-91.
19. Diener HC, Limmroth V. A practical guide to the management and prevention of migraine. *Drugs* 1998; 56: 811-24.
20. Peroutka S. Drugs effective in the therapy of migraine, Hardman J, Goodman A, Gilman, Limbird L (eds): *Goodman & Gilman's The pharmacological basis of therapeutics*, New York, 1996, pp487-502.
21. Silberstein SD. Practice parameter: evidenced based guidelines for migraine headache (an evidenced-based review): Report of the quality standards subcommittee of the American Academy of Neurology. *Neurology* 2000; 55 (6): 754-63.
22. Spierings E, Gomez-Mancilla B, Grosz D, Rowland C, Whaley F, Jirgens K. Almotriptan vs oral sumatriptan in the abortive treatment of migraine. *Arch Neurol* 2001; 58: 944-950.
23. Pascual J, Falk RM, Piessens F, et al. Consistent efficacy and tolerability of almotriptan in the acute treatment of multiple migraine attacks: results of a large randomized double-blind placebo-controlled study. *Cephalalgia* 2000; 20: 588-596.
24. Cabarrocas X, Esbri R, Peris F, Ferrer P. Long-term efficacy and safety of oral almotriptan: interim analysis of a 1-year open study. *Headache* 2001; 41: 57-62.
25. Colman SS, Brod MI, Krishnamurthy A, Rowland CR, Jirgens K. Treatment satisfaction, functional status, and other health related quality of life of migraine patients treated with almotriptan or sumatriptan. *Clin Ther* 2001; 23: 127-145.
26. Fleishaker JC, Sisson TA, Carel BJ, Azie NE. Lack of pharmacokinetic interaction between the antimigraine compound almotriptan and propranolol in health volunteers. *Cephalalgia* 2001; 21: 61-65.
27. Fleishaker JC, Sisson TA, Carel BJ, Azie NE. Pharmacokinetic interaction between verapamil and almotriptan in healthy volunteers. *Clin Pharmacol Ther* 2000; 67: 498-503.
28. <http://headaches.about.com/bl-glossary-b.htm>.