PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
For migraine headache therapy: *Emgality (galcanezumab)*

Please fax form to: 1-866-840-1509

Please note that the patient **AND** physician must complete this form. **All fields are mandatory and must be completed. Incomplete forms may result in your application being declined.** Please retain a copy of this form for your records.

Instructions:

1. **PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to **1-866-840-1509**.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

A. Information to be Completed by Patient

Employee or Insured's Name	Drug Card Number __ __ - __ __ __ __ __ __ - __ __ __ __ __ __ __ __ __ __ - __ __	
Patient's Name	Patient's Date of Birth (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	Relationship to Employee/Insured ❑Employee ❑Spouse ❑Dependent

Please allow two business days for a response once all information is received and complete.
Notification of the results of this request will occur Monday to Friday between 9 am and 4 pm Eastern Time.

Please provide contact information and indicate **ONE** method of preferred contact for notification of the results:

❑ E-mail	❑ Call me (and leave a message if I'm not there)	❑ Fax me at:
❑ Contact my pharmacy: Pharmacy Name		Pharmacy Phone Number

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN _____

Date: (DD/MMM/YYYY): __ __ / __ __ __ / __ __ __ __

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B. Information to be Completed by Prescribing Physician

Drug Name	Strength	Dose
Emgality (galcanezumab)		

***Emgality (galcanezumab)* will be eligible for reimbursement only if the patient satisfies the conditions listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program**. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If "None of the above criteria" is indicated, the patient will not be eligible for reimbursement. **For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.**

Eligibility Criteria

Please indicate if the patient satisfies one of the following criteria:

Initial Criteria (approval period of 24 weeks):

- ❑ For prevention of migraine (37796009) in patients who have at least 4 migraine days per month, **AND**
  - ❑ Patient is ≥18 years of age,
  - ❑ Individual has had a trial of and experienced inadequate response or intolerance to at least **one agent in any two of the following classes** of accepted migraine prevention agents
    - ❑ One or more antidepressants (e.g. amitriptyline, venlafaxine); OR
    - ❑ One or more beta blockers (e.g. metoprolol, propranolol, oral timolol, nadolol, atenolol, nebivolol); OR
    - ❑ One or more calcium channel blockers (e.g. verapamil or flunarizine); OR
    - ❑ One or more antiepileptic agents (e.g. valproic acid, topiramate, gabapentin); OR
    - ❑ Botox (for chronic migraine in those experiencing ≥15 headache days per month with headache lasting 4 hours a day or longer)
  - ❑ Prescriber is experienced in the diagnosis and treatment of migraine.

Initial Criteria (approval period of 3 weeks):

- ❑ For the reduction in the frequency of attacks throughout a cluster period in adults with episodic cluster headache (230472004), **AND**
- ❑ The patient
  - ❑ Is ≥18 years of age; **AND**
  - ❑ Has a diagnosis of cluster headache as defined by International Headache Society (IHS) International Classification of Headache Disorders 3rd edition guidelines
  - ❑ Has a prior history of cluster headache periods lasting at least 6 weeks; **AND**
  - ❑ Has had an inadequate response to, or tolerated poorly, or had contraindications to conventional preventive therapies established by Canadian practice guidelines, including:
    - ❑ Verapamil; **AND**
    - ❑ Lithium; **AND**
    - ❑ Topiramate

  AND
- ❑ The prescriber is experienced in the diagnosis and treatment of episodic cluster headache

Renewal Criteria (approval period of 1 year):

- ❑ Prevention of migraine (37796009)
  - ❑ Patient has experienced a reduction in the overall number of migraine days or reduction in number of severe migraine days per month;

- ❑ Reduction in episodic cluster headache (230472004)
  - ❑ Patient has experienced a reduction in weekly cluster headache attack frequency

  NOTE: Emgality should not be used after the end of a cluster period and during the remission time

  OR

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Eligibility Criteria
❑ None of the above applies Relevant additional information _____

Physician Information				
Physician's Name	License Number	Telephone Number	Fax Number	
Address		City	Province	Postal Code
Physician's Signature			Date: (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	