Emgality (galcanezumab-gnlm)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ **Episodic migraine** ☐ **Chronic migraine** ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Will patient use in combination with another CGRP product for prevention and/or acute migraines?
☐ **Yes** ☐ **No ---PATIENT IS NOT ALLOWED COMBINATION USE OF 2 CGRP'S OF ANY KIND—**

If patient is using a CGRP product for acute migraines and prescriber would like to use Emgality(galcanezumab-gnlm) for prevention, is prescriber ok with terming use of the CGRP for acute migraine treatment in lieu of using a CGRP for prevention? ☐ **Yes** ☐ **No** ***Any current active PA for an acute CGRP will be termed.***

Initial Request:

Has the patient had at least 4 migraine days per month? □ **Yes** □ **No** ***Please submit chart documentation.***

Is the prescriber a neurologist or has UCNS accreditation in Headache Medicine? □ **Yes** □ **No**

Is the prescriber board certified in pain management? □ **Yes** □ **No**

Has the patient tried at least two(2) migraine preventive treatment categories? □ **Yes** □ **No** ***Please submit chart documentation with dates of service.***

□ **Beta Blocker**
□ **Anti-depressant**
□ **Anti-epileptic (excludes benzodiazepines)**
□ **Ca++Channel Blocker**
□ **Angiotension-2 receptor blocker(ARB)**
□ **Botox**

Has the patient been evaluated for overuse headache due to triptans, ergot derivatives, opioid analgesics, non-opioid analgesics and combination products? □ **Yes** □ **No**

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Renewal Request:

Please submit chart documentation showing a positive clinical response, as demonstrated by the presence of at least one of the following since starting Aimovig: decreased migraine frequency AND/OR decreased migraine severity AND/OR improved daily functioning on the part of the patient.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909

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