TRICARE Prior Authorization Request Form for
galcanezumab – gnlm **(Emgality) 100mg**

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization for initial therapy will approve for 6 months. Prior authorization for continuation of therapy does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Emgality*	☐ Yes Proceed to question **8**	☐ No Proceed to question **2**
2. Is this medication being prescribed by or in consultation with a neurologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the patient GREATER THAN or EQUAL TO 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **5**
5. For which indication is the requested medication being prescribed?	☐ EPISODIC cluster headaches - Proceed to question **6** ☐ migraine prophylaxis – **STOP** Coverage not approved ☐ CHRONIC cluster headache – **STOP** Coverage not approved ☐ medication overuse headache – **STOP** Coverage not approved ☐ Other - **STOP** Coverage not approved	
6. Does the patient have a contraindication to, intolerability to, or has failed an adequate trial of Verapamil, topiramate, OR lithium?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
7. Will the patient use other prophylaxis calcitonin gene-related peptide (CGRP) inhibitors (such as Aimovig or Ajovy) in combination with the requested medication? Note: This does not include the CGRP targeted abortive inhibitors (for example, another "gepant", Nurtec or Ubrelvy).	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

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8. Has the patient had a clinically appropriate (greater than or equal to 50% reduction in weekly cluster headache attack frequency) reduction in weekly attacks during an episode?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[6 January 2021]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: