Prior Authorization Request Form for galcanezumab – gnlm **(Emgality) 120mg**

JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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.

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:

Question		
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 **16**	☐ 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. What is the indication or diagnosis?	☐ Chronic migraines - Proceed to question **9** ☐ Episodic migraines - Proceed to question **6** ☐ All other diagnosis or indications – **STOP Coverage not approved**	
6. Has the patient experienced three consecutive months of 8 migraine days per month?	☐ Yes Proceed to question **9**	☐ No Proceed to question **7**
7. Has the patient experienced three consecutive months of 4-7 migraine days per month?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Does the patient have at least moderate disability shown by Migraine Disability Assessment (MIDAS) Test score greater than 11 or Headache Impact Test-6 (HIT-6) score greater than 50?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved

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Question	Yes	No
9. Is the patient currently on botulinum toxin or has the patient received a botulinum toxin injection within the last 2 months?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **10**
10. Will the patient use another calcitonin gene-related peptide (CGRP) inhibitors (such as Aimovig or Ajovy) in combination with the requested medication?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **11**
11. Please note for the following questions, formulary migraine prophylactic drug classes include: • Prophylactic antiepileptic medications: valproate, divalproic acid, topiramate; • Prophylactic beta-blocker medications; metoprolol, propranolol, atenolol, nadolol, timolol; • Prophylactic antidepressants: amitriptyline, duloxetine, nortriptyline, venlafaxine.	Proceed to question **12**	
12. Has the patient tried at least ONE drug from TWO of the above migraine prophylactic drug classes?	☐ Yes Proceed to question **13**	☐ No Proceed to question **14**
13. Has the patient experienced intolerance or failure after an adequate 2 month trial of at least ONE drug from TWO of the above migraine prophylactic drug classes? *(An adequate trial is generally considered to be 6 to 8 weeks in duration because of the amount of time required to achieve maximal benefit with therapy.)*	☐ Yes Proceed to question **15**	☐ No **STOP** Coverage not approved
14. Does the patient have a contraindication to at least ONE drug from TWO of the above migraine prophylactic drug classes?	☐ Yes Proceed to question **15**	☐ No **STOP** Coverage not approved
15. Is the loading dose required?	☐ Yes **Sign and date below**	☐ No **Sign and date below**
16. Has the patient had a reduction in mean monthly headache days of GREATER THAN OR EQUAL TO 50% relative to the pretreatment baseline (as shown by patient diary documentation or healthcare provider attestation)?	☐ Yes **Sign and date below**	☐ No Proceed to question **17**
17. Has the patient shown a clinically meaningful improvement in ANY of the following validated migraine-specific patient-reported outcome measures: **A) Migraine Disability Assessment (MIDAS):** • **a reduction of 5 points or more when baseline score is 11-20 or** • **a reduction of 30% or more when baseline score is greater than 20** **B) Headache Impact Test (HIT-6): a reduction of 5 points or more;** **C) Migraine Physical Functional Impact Diary (MPFID): a reduction of 5 points or more**	☐ 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

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