

## FREMANEZUMAB/ GALCANEZUMAB For Migraine Prevention SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

ALBERTA PERSONAL HEALTH NUMBER   FIRST NAME   INITIAL   Alberta Blue Cross-   Alberta Human Services   Other   ADDRESS   CITY   PROV   POSTAL CODE   IDICLIENT/COVERAGE NUMBER	PATIEN	IT INFORMATION					COVE	PAGE T	YPF			
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ALBERTA PERSONAL HEALTH NUMBER    Other		- ···-		,				∐ Alb	erta Blu	e Cross		
ADDRESS CITY PROV POSTAL CODE IDICLIENT/COVERAGE NUMBER  PRESCRIBER INFORMATION  PRESCRIBER LAST NAME FIRST NAME INITIAL    PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION     CPSA   ACP   Other  CITY, PROVINCE   PHONE   FAX    PH	BIRTH	DATE (YYYY-MM-DD)	ALBERTA PERSONA	ALBERTA PERSONAL HEALTH NUMBER				☐ Alb	erta Hu	man Services		
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LLNO provide recease why eral prophylactic migrains medications cannot be tried												
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Section II: Complete the following for all RENEWAL requests and INITIAL requests for treatment experienced patients												
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1) Current average number of migraine days per month Date												
Additional information relating to request												
PRESCRIBER'S SIGNATURE DATE (YYYY-MM-DD) Please forward this request to	PRESC	CRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	(YYYY-MM-DD) Please forward this re			auest to					
Alberta Blue Cross, Clinical Drug Services	1100	ALLE CONTROLL		Alberta Blue Cros			s, Clinical Drug Services					
10009 108 Street NW, Edmonton, Alberta 15J 3C5  FAX 780-498-8384 in Edmonton • 1-877-828-4106 toll free all other areas				10009 108 Street NW, Edmonton, Alberta T5J 3C5 FAX <b>780-498-8384</b> in Edmonton • <b>1-877-828-4106</b> toll free all other areas								

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

