ALBERTA BLUE CROSS®

FREMANEZUMAB/ GALCANEZUMAB
For Migraine Prevention
SPECIAL AUTHORIZATION REQUEST FORM

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

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

PATIENT INFORMATION				COVERAGE TYPE
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

1) Indicate requested drug: ☐ Fremanezumab (Ajovy) ☐ Galcanezumab (Emgality)

2) Diagnosis

☐ CHRONIC migraine defined as experiencing headaches for at least 15 days per month for more than three months of which at least eight days per month of this period are with migraine

☐ EPISODIC migraine defined as experiencing headaches for less than 15 days per month for more than three months of which at least four days per month of this period are with migraine

☐ Other (specify) _____

3) Dose and frequency requested

4) Combination therapy Will the requested drug be used in combination with onabotulinumtoxinA for the prevention of migraine?	☐ YES	☐ NO
5) The requesting physician has appropriate experience in the management of patients with migraine headaches	☐ YES	☐ NO

Section I: Please provide <u>pre-treatment</u> information for NEW requests for treatment-naïve and treatment-experienced patients

1) Pre-treatment average number of migraine days per month _____ Date _____

2) Previous medications utilized

Has the patient been refractory or intolerant to at least TWO **<u>ORAL</u>** prophylactic migraine medications of different classes?

☐ YES (please **SPECIFY** below)

	Please **SPECIFY** the medication	Please **SPECIFY** the dose, duration and response
Medication #1		
Medication #2		

☐ NO, provide reasons why oral prophylactic migraine medications cannot be tried

_____

Section II: Complete the following for all RENEWAL requests and INITIAL requests for treatment experienced patients

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 **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

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