PEHP Health & Benefits

Emgality® *(galcanezumab)* and Ajovy™ *(fremanezumab)*

PRIOR AUTHORIZATION REQUEST FORM

For authorization, answer each question, include patient chart notes to document clinical information, **and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

Include patient chart notes to document clinical information

Date:	Patient Name:	ID #:
D.O.B:	Prescriber:	Prescriber NPI:
Office Fax:	Office Phone:	Office Contact:
Sex: / Weight:	Authorization is requested from:	to

1. Select the medication being requested: ☐ Emgality® ☐ Ajovy™
2. Indicate the patient's dose, frequency, and instructions below:

Dose:		**Strength**:		**Frequency**:	
Instructions:					

3. Indicate the patient's diagnosis: ☐ Prophylaxis of chronic migraine ☐ Cluster headache
   ☐ Other* (list):

*Include clinical studies, other supporting literature, and chart notes for other indications

4. Indicate which of the following migraine prophylaxis medication classes the patient has had a 60-day trial and failure, or contraindication:
   - ☐ Tricyclic antidepressants or TCA's (amitriptyline, imipramine, doxepin, mirtazapine, nortriptyline)
   - ☐ Venlafaxine
   - ☐ Anti-epileptic drugs (i.e. gabapentin, topiramate, valproic acid)
   - ☐ Beta blockers (i.e. atenolol, metoprolol, propranolol)
   - ☐ Calcium channel blockers (i.e. diltiazem, verapamil)
   - ☐ ACE inhibitor/ARB (i.e. lisinopril, losartan)
   - ☐ None

Question	Yes	No	Comments/Notes
5. Is the provider a neurologist or has a consult been obtained with a neurologist?	☐	☐	Include documentation from consult
6. Is the patient 18 years of age or older?	☐	☐	
7. Does the patient experience migraines on ≥ 15 days per month?	☐	☐	
8. Does each of the patient's migraines last ≥ 4 hours a day in duration?	☐	☐	
9. Is the patient receiving preventative migraine treatment with Botox®?	☐	☐	
10. Is the patient receiving chronic opioid therapy?	☐	☐	
11. If the patient is on chronic opioids, is there documentation or intent to taper their current opioid dose following initiation CGRP therapy?	☐	☐	
12. If the diagnosis is cluster headaches, has the patient experienced ≥ 2 cluster periods, lasting 7-365 days separated by at least 90 days of pain free periods?	☐	☐	
13. Has the patient received previous therapy with Emgality® or Ajovy™ and this is a request for retreatment/continued therapy?	☐	☐	
14. If this request is for retreatment/continued therapy can you provide documentation the patient has experienced a decrease in the number of headache days?	☐	☐	

15. Physician's signature: