OKLAHOMA Health Care Authority

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State of Oklahoma
SoonerCare
Emgality® (galcanezumab-gnlm) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

Pharmacy billing (NDC:_____) Start Date (or date of next dose):_____

Dose: _____ Regimen:_____ Fill Quantity:_____ Day Supply:_____

Pharmacy Information

Pharmacy NPI:_____ Pharmacy Name:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization:

1. What is the member's diagnosis?
   - ☐ Chronic migraines
   - ☐ Episodic migraines
   - ☐ Episodic cluster headaches
   - ☐ Other, please list:_____
2. Will member use Emgality® concurrently with botulinum toxin for the prevention of migraine or with an alternative CGRP inhibitor? Yes☐ No☐
3. Has the member been counseled on appropriate use, administration technique, and storage of Emgality®? Yes☐ No☐
4. Has the member been evaluated for all of the following, as defined by the American Headache Society, and these conditions have been ruled out and/or treated:
   a. Red flags? Yes☐ No☐
   b. Possible indicators of secondary headache? Yes☐ No☐
   c. Medication overuse? (for diagnosis of migraines only) Yes☐ No☐
5. If diagnosis is **preventative treatment of migraines**, please complete the following:
   a. Date of member's migraine diagnosis: _____
   b. Number of headache days per month: _____
   c. Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months): _____
   d. If approved, will member require a loading dose for initial treatment with Emgality®? Yes☐ No☐
6. If diagnosis is **treatment of episodic cluster headache**, please complete the following:
   a. Does member have a diagnosis of episodic cluster headache according to the International Classification of Headache Disorders (ICHD-3)? Yes☐ No☐
   b. Frequency of cluster headache attacks: _____ per day; _____ per week
   c. Does member have a history of episodic cluster headache with at least 2 cluster periods lasting from 7 days to 1 year (when untreated) and separated by pain-free remission periods of ≥3 months? Yes☐ No☐

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Criteria

For Continued Authorization (compliance and information regarding efficacy will be required for continued approval):

1. Has the member been compliant with Emgality® (galcanezumab-gnlm) treatment? Yes☐ No☐
2. Has the member responded well to treatment with Emgality® (galcanezumab-gnlm)? Yes☐ No☐
3. For ***preventative treatment of migraines,*** please provide the member's current number of migraine days per month:_____
4. For ***treatment of episodic cluster headache,*** please provide the member's current cluster headache attack frequency:_____ per day _____ per week

Additional Information: _____

_____

_____

_____

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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