US Family Health Plan
Prior Authorization Request Form for
galcanezumab – gnlm **(Emgality) 100mg**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization for initial therapy will approve for 6 months. Prior authorization for continuation of therapy does not expire.

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:

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 **8**	☐ 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. For which indication is the requested medication being prescribed?	☐ EPISODIC cluster headaches - Proceed to question **6** ☐ migraine prophylaxis – **STOP** Coverage not approved ☐ CHRONIC cluster headache – **STOP** Coverage not approved ☐ medication overuse headache – **STOP** Coverage not approved ☐ Other - **STOP** Coverage not approved	
6. Does the patient have a contraindication to, intolerability to, or has failed an adequate trial of Verapamil, topiramate, OR lithium?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
7. 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 **Sign and date below**

8. Has the patient had a clinically appropriate (greater than or equal to 50% reduction in weekly cluster headache attack frequency) reduction in weekly attacks during an episode?	☐ 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

[11 September 2019]