

# US Family Health Plan

## Prior Authorization Request Form for galcanezumab – gnlm (**Emgality**) 120mg

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 855-273-5735**

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.

[usfamilyhealth.org/rx-pa](http://usfamilyhealth.org/rx-pa)

**Step 1** Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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**Step 2** Please complete the clinical assessment:

1. Has the patient received this medication under the <b>TRICARE</b> benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for Emgality</i>	<input type="checkbox"/> Yes Proceed to question <b>15</b>	<input type="checkbox"/> No Proceed to question <b>2</b>
2. Is this medication being prescribed by or in consultation with a neurologist?	<input type="checkbox"/> Yes Proceed to question <b>3</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. Is the patient <b>GREATER THAN</b> or <b>EQUAL TO</b> 18 years of age?	<input type="checkbox"/> Yes Proceed to question <b>4</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
4. Is the patient pregnant or actively trying to become pregnant?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question <b>5</b>
5. What is the indication or diagnosis?	<input type="checkbox"/> Chronic migraines - Proceed to question <b>9</b> <input type="checkbox"/> Episodic migraines - Proceed to question <b>6</b> <input type="checkbox"/> All other diagnosis or indications – <b>STOP</b> <b>Coverage not approved</b>	
6. Has the patient experienced three consecutive months of 8 migraine days per month?	<input type="checkbox"/> Yes Proceed to question <b>9</b>	<input type="checkbox"/> No Proceed to question <b>7</b>
7. Has the patient experienced three consecutive months of 4-7 migraine days per month?	<input type="checkbox"/> Yes Proceed to question <b>8</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
8. Does the patient have at least moderate disability shown by Migraine Disability Assessment (MIDAS) Test score greater than 11 or Headache Impact Test-6 (HIT-6) score greater than 50?	<input type="checkbox"/> Yes Proceed to question <b>9</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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<b>9. Will the patient use another calcitonin gene-related peptide (CGRP) inhibitors (such as Aimovig or Ajovy) in combination with the requested medication?</b>	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question <b>10</b>
<b>10. Please note for the following questions, formulary migraine prophylactic drug classes include:</b> <ul style="list-style-type: none"> <li>• Prophylactic antiepileptic medications: valproate, divalproic acid, topiramate;</li> <li>• Prophylactic beta-blocker medications; metoprolol, propranolol, atenolol, nadolol, timolol;</li> <li>• Prophylactic antidepressants: amitriptyline, duloxetine, nortriptyline, venlafaxine.</li> </ul>	Proceed to question <b>11</b>	
<b>11. Has the patient tried at least ONE drug from TWO of the above migraine prophylactic drug classes?</b>	<input type="checkbox"/> Yes Proceed to question <b>12</b>	<input type="checkbox"/> No Proceed to question <b>13</b>
<b>12. Has the patient experienced intolerance or failure after an adequate 2 month trial of at least ONE drug from TWO of the above migraine prophylactic drug classes?</b> <i>(An adequate trial is generally considered to be 6 to 8 weeks in duration because of the amount of time required to achieve maximal benefit with therapy.)</i>	<input type="checkbox"/> Yes Proceed to question <b>14</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>13. Does the patient have a contraindication to at least ONE drug from TWO of the above migraine prophylactic drug classes?</b>	<input type="checkbox"/> Yes Proceed to question <b>14</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>14. Is the loading dose required?</b>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>Sign and date below</b>
<b>15. Has the patient had a reduction in mean monthly headache days of GREATER THAN OR EQUAL TO 50% relative to the pretreatment baseline (as shown by patient diary documentation or healthcare provider attestation)?</b>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No Proceed to question <b>16</b>
<b>16. Has the patient shown a clinically meaningful improvement in ANY of the following validated migraine-specific patient-reported outcome measures:</b> <b>A) Migraine Disability Assessment (MIDAS):</b> <ul style="list-style-type: none"> <li>• a reduction of 5 points or more when baseline score is 11-20 or</li> <li>• a reduction of 30% or more when baseline score is greater than 20</li> </ul> <b>B) Headache Impact Test (HIT-6):</b> a reduction of 5 points or more; <b>C) Migraine Physical Functional Impact Diary (MPFID):</b> a reduction of 5 points or more	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

**Step  
3**

I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_

Prescriber Signature

\_\_\_\_\_

Date