State of Oklahoma
Oklahoma Health Care Authority
Emgality® (Galcanezumab-gnlm) Prior Authorization Form

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

Drug Information

***Pharmacy billing (NDC:*_____) *Start Date:*_____ *Dose:*_____**

***Regimen:*_____ *Fill Quantity:*_____ *Day Supply:*_____**

Billing Provider Information

***Pharmacy NPI:*_____ Pharmacy *Name:*_____**

***Pharmacy Phone:*_____ *Pharmacy Fax:*_____**

Prescriber Information

***Prescriber NPI:*_____ *Prescriber Name:*_____**

***Prescriber Phone:*_____ *Prescriber Fax:*_____ *Specialty:*_____**

Criteria

All information must be provided and SoonerCare may verify through further requested documentation. The member's prescription claim history will be reviewed prior to approval.

Page 1 of 2 — Please complete and return all pages. *Failure to complete all pages will result in processing delays.*

For Initial Authorization:

1. What is the member's diagnosis?
   - ❑ Chronic migraines
   - ❑ Episodic migraines
   - ❑ Episodic cluster headaches
   - ❑ Other, please list:_____
2. Is the member taking any of the following medications **known** to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain?
   a. Decongestants (alone or in combination products)? Yes☐ No☐
   b. Combination analgesics containing caffeine and/or butalbital? Yes☐ No☐
   c. Opioid-containing medications? Yes☐ No☐
   d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes☐ No☐
   e. Ergotamine-containing medications? Yes☐ No☐
   f. Triptans? Yes☐ No☐
3. If member is taking any of the medication(s) listed in Question 2, please list the medication(s) and the number of days per month taken:_____
4. If member is taking any of the medication(s) listed in Question 2, please provide additional information to support member's need for continued use of medication(s) known to cause overuse or rebound headaches:
   _____
   _____
5. Was Emgality® prescribed by or in consultation with a neurologist? Yes☐ No☐
   a. If yes, please include name of neurologist recommending Emgality® treatment_____
6. Will member use Emgality® concurrently with botulinum toxin for the prevention of migraine or with an alternative CGRP inhibitor? Yes☐ No☐
7. Has the member been counseled on appropriate use, administration technique, and storage of Emgality®? Yes☐ No☐

Complete and return all pages. Failure to complete all pages will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Emgality® (Galcanezumab-gnlm) Prior Authorization Form

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

Criteria

Page 2 of 2 — Please complete and return all pages. *Failure to complete all pages will result in processing delays.*

For Initial Authorization (continued):

8. 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. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated?
      i. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes☐ No☐
      ii. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes☐ No☐
   e. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated?
      i. Hormone replacement therapy or hormone-based contraceptives? Yes☐ No☐
      ii. Chronic insomnia? Yes☐ No☐
      iii. Obstructive sleep apnea? Yes☐ No☐
   f. Has the member failed at least 2 different types of medications typically used for migraine prevention [e.g., select antihypertensives (such as beta-blockers), select anticonvulsants (such as valproate or topiramate), select antidepressants (such as amitriptyline or venlafaxine)]? Yes☐ No☐ If yes, please list:
      Medication_____ Date Span_____ Dosing_____
      Medication_____ Date Span_____ Dosing_____
   g. Is the member taking any medications that are **likely** to be the cause of the headaches? Yes☐ No☐
   h. If applicable, are other aggravating factors that contribute to the development of episodic/chronic migraine headaches being treated (e.g., smoking)? Yes☐ No☐ NA☐
   i. If approved, will member require a loading dose for initial treatment with Emgality®? Yes☐ No☐
9. 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 ≥1 month? Yes☐ No☐
   d. Has the member failed at least 1 prophylactic medication for cluster headache (e.g., verapamil, select anticonvulsants)? Yes☐ No☐ If yes, please list:
      Medication_____ Date Span_____ Dosing_____

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

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.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*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.*