BlueCross BlueShield Federal Employee Program

EMGALITY
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Emgality (galcanezumab-gnlm)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. **Please select the strength and answer the following questions:**

❑Emgality 100mg/mL (galcanezumab-gnlm)

a. Is this medication being used for the treatment of episodic cluster headaches? ❑Yes ❑No

b. Will the patient need more than 9 injections every 90 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ injections per 90 days

c. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following question:

i. Does the patent have an intolerance or contraindication to at least **ONE** of the following: triptan agent, ergotamine tartrate, or dihydroergotamine? ❑Yes ❑No*

If NO, has the patient completed an adequate 3-month trial of at least **ONE** of the following: triptan agent, ergotamine tartrate, or dihydroergotamine? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient had a decrease in frequency of cluster headache attacks? ❑Yes ❑No

d. Will the patient require TWO calcitonin gene-related peptide (CGRP) antagonist medications for migraine therapy? ***Please select answer below:***

❑ **YES**, Emgality is for episodic cluster headaches and will be used with another CGRP for ACUTE treatment of migraines (Nurtec, Ubrelvy, Zavzpret).

❑ **YES**, Emgality is for episodic cluster headaches and will be used with another CGRP for PREVENTATIVE Treatment of migraines (Ajovy, Ajovy, Qulipta, Vyepti, Nurtec).

❑ **NO**, Emgality is for episodic cluster headaches and the patient will be stopping the current CGRP therapy.

❑ **NO**, Emgality is the ONLY CGRP the patient will be using.

❑Emgality 120mg/mL (galcanezumab-gnlm)

a. Is this medication being used for the prevention of migraines? ❑Yes ❑No

b. Will the patient require TWO calcitonin gene-related peptide (CGRP) antagonist medications for migraine therapy? ***Please select answer below:***

❑ **YES**, Emgality is for PREVENTATIVE treatment and will be used with another CGRP for ACUTE treatment of migraines (Nurtec, Ubrelvy, Zavzpret). Acute and preventative CGRP combination therapy is covered if the patient is treatment resistant. **Please answer the below question:**

1) Has the patient completed an adequate 3-month trial of at least **TWO** of the following preventative CGRP antagonists: Aimovig, Ajovy, Emgality, Nurtec ODT, Qulipta, and/or Vyepti? ❑Yes ❑No*

If NO, has the patient completed an adequate 3-month trial of a triptan agent in combination with **ONE** of the preventative CGRP antagonists? ❑Yes ❑No

❑ **YES**, Emgality is for PREVENTATIVE treatment and will be used with another CGRP for PREVENTATIVE Treatment of migraines (Emgality, Ajovy, Qulipta, Vyepti, Nurtec).

❑ **NO**, Emgality is for PREVENTATIVE treatment and the patient will be stopping the current CGRP therapy.

❑ **NO**, Emgality is the ONLY CGRP the patient will be using.

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

c. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Has the patient taken a preventative calcitonin gene-related peptide (CGRP) medication in the past or is the patient switching from another preventative CGRP medication? ❑Yes ❑No*****

****If NO***, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **TWO** of the following prophylactic agents: divalproex sodium/valproate sodium (Depakote/Depakote ER), topiramate (Topamax), amitriptyline (Elavil), nortriptyline (Pamelor), venlafaxine (Effexor), duloxetine (Cymbalta), or a beta-blocker such as atenolol, metoprolol, nadolol, propranolol, and timolol? ❑Yes ❑No

ii. Will the patient need more than 7 injections for a 180 day supply? ❑Yes***** ❑No

****If YES***, please specify the requested quantity: _____ injections per 180 days

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has the patient had a documented decrease in migraine days from baseline **OR** an improvement in daily activities due to the reduction of debilitating migraines? ❑Yes ❑No

ii. Will the patient need more than 3 injections every 90 days? ❑Yes***** ❑No

****If YES***, please specify the requested quantity: _____ injections per 90 days