Prescriber Criteria Form

Emgality 2025 PA Fax 3111-A v1 010125.docx
Emgality (galcanezumab-gnlm)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Emgality (galcanezumab-gnlm).

Drug Name:
Emgality (galcanezumab-gnlm)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the preventive treatment of migraine? [If no, then skip to question 6.]	Yes ◯	No ◯
2	Has the patient received at least 3 months of treatment with the requested drug? [If no, then skip to question 4.]	Yes ◯	No ◯
3	Has the patient had a reduction in migraine days per month from baseline? [No further questions.]	Yes ◯	No ◯
4	Has the patient experienced an inadequate treatment response with a 4-week trial of any one of the following: A) antiepileptic drugs (AEDs), B) beta-adrenergic blocking agents, C) antidepressants? [If yes, then no further questions.]	Yes ◯	No ◯
5	Has the patient experienced an intolerance or does the patient have a contraindication that would prohibit a 4-week trial of any one of the following: A) antiepileptic drugs (AEDs), B) beta-adrenergic blocking agents, C) antidepressants? [No further questions.]	Yes ◯	No ◯
6	Is the requested drug being prescribed for the treatment of episodic cluster headaches? [If no, then no further questions.]	Yes ◯	No ◯

7	Has the patient received at least 3 weeks of treatment with the requested drug? [If no, then skip to question 9.]	Yes ◯	No ◯
8	Has the patient had a reduction in weekly cluster headache attack frequency from baseline? [No further questions.]	Yes ◯	No ◯
9	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to a triptan 5-HT1 receptor agonist?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____