BRITISH COLUMBIA | Ministry of Health

*PHARMACARE SPECIAL AUTHORITY REQUEST*

# CGRP ANTAGONISTS FOR MIGRAINE PREVENTION

HLTH 5822 Rev. 2024/04/15

◯ **INITIAL**
**Complete sections 1 – 4**

◯ **SWITCH**
**Complete sections 1 – 3, & 5**

◯ **RENEWAL**
**Complete sections 1 – 3, & 6**

**For up-to-date criteria and forms, please check: www.gov.bc.ca/pharmacarespecialauthority**

**Fax requests to 1-800-609-4884 (toll free) OR mail requests to: PharmaCare, Box 9652 Stn Prov Govt, Victoria, BC V8W 9P4**
This facsimile is doctor-patient privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited.

If PharmaCare approves this Special Authority request, approval is granted solely for the purpose of covering prescription costs. PharmaCare approval does not indicate that the requested device is, or is not, suitable for any specific patient or condition.

If you have received this fax in error, please write MISDIRECTED across the front of the form and fax toll-free to 1-800-609-4884, then destroy the pages received in error.

***Forms with information missing will be returned for completion. If no prescriber fax or mailing address is provided, PharmaCare will be unable to return a response.***

## SECTION 1 – PRESCRIBER'S INFORMATION

| Prescriber's Name and Mailing Address | |
|---|---|
| College ID (use ONLY College ID number) | Phone Number (include area code) |
| **CRITICAL FOR A TIMELY RESPONSE →** | Prescriber's Fax Number |

## SECTION 2 – PATIENT INFORMATION

| Patient (Family) Name | |
|---|---|
| Patient (Given) Name(s) | |
| Date of Birth (yyyy / mm / dd) | Date of Application (yyyy / mm / dd) |
| **CRITICAL FOR PROCESSING →** | Personal Health Number (PHN) |

## SECTION 3 – MEDICATION REQUESTED

| | | |
|---|---|---|
| ◯ fremanezumab 225 mg/1.5 mL 9901-0395<br>225 mg SC once monthly or<br>675 mg SC every 3 months | ◯ galcanezumab 120 mg/mL 9901-0395<br>240 mg SC as a single loading dose,<br>followed by 120 mg SC once monthly | ◯ eptinezumab 9901-0452<br>100 mg/mL<br>100 mg or 300 mg IV once every 12 weeks |

## SECTION 4 – CRITERIA FOR INITIAL COVERAGE: 6 MONTHS

Practitioner making this request has appropriate experience in the management of patients with migraine headaches

**Approvals subject to ALL of the criteria below being met (mark boxes and complete blanks as applicable):**

**A.** ◯ Patient has a confirmed diagnosis of **episodic** migraine (defined as migraine headaches on at least 4 days per month and less than 15 headache days per month for more than 3 months)

OR ◯ Patient has a confirmed diagnosis of **chronic** migraine (defined as migraine headache on at least 8 days per month and headaches for at least 15 days per month for more than 3 months)

**B.** Specify the current average number of migraine days per month (i.e., calculated using data from a migraine diary/app kept by the patient over the 3 month period immediately preceding this request). PharmaCare will not accept changes to this baseline number on future renewal requests.

| Date Average Calculated (YYYY / MM) | Average number migraine days/month (Please note: <, >, ranges or headache (HA) days are not accepted) |
|---|---|
| | |

**C.** ☐ Patient has experienced an inadequate response (minimum 3 months trial at optimal dosing) or intolerance to **at least two oral** prescription prophylactic migraine medications from **two** different therapeutic classes. For a list of oral prophylactic medications and daily doses accepted please consult the fremanezumab, galcanezumab, or eptinezumab limited coverage criteria page or the eForm. Please note: Injectable prophylactic medications and medications used for acute migraine treatment are NOT accepted.

| Name of Medication Trialed and Daily Dose | Duration of Trial | Reason for Discontinuation | Provide Details of Intolerance(s) |
|---|---|---|---|
| | | ◯ Inadequate response<br>◯ Intolerance(s): details → | |
| | | ◯ Inadequate response<br>◯ Intolerance(s): details → | |
| | | ◯ Inadequate response<br>◯ Intolerance(s): details → | |
| | | ◯ Inadequate response<br>◯ Intolerance(s): details → | |
| | | ◯ Inadequate response<br>◯ Intolerance(s): details → | |

**Please complete additional information on page 2 >>**

HLTH 5822

# CGRP ANTAGONISTS FOR MIGRAINE PREVENTION

| Patient (Family) Name | Patient (Given) Name(s) | Personal Health Number (PHN) |
|---|---|---|
| | | |

## SECTION 5 – SWITCHING TO ANOTHER CGRP ANTAGONIST: 6 months

Name and dose of CGRP antagonist being discontinued: _____

Date CGRP antagonist was discontinued: _____

Reason for discontinuation of prior CGRP antagonist

- ☐ Patient failed to achieve a minimum 50% reduction in the average number of migraine days per month compared to baseline.
- ☐ Patient failed to maintain a minimum 50% reduction in the average number of migraine days per month compared to baseline.
- ☐ Other (please specify): _____

**Specify the current average number of migraine days per month calculated over the past 3 months**

| Date Average Calculated (YYYY / MM) | Average number migraine days/month (Please note: <, >, ranges or headache (HA) days are not accepted) |
|---|---|
| | |

## SECTION 6 – CRITERIA FOR RENEWAL: FIRST RENEWAL 6 MONTHS, SECOND AND SUBSEQUENT RENEWALS 1 YEAR

Practitioner making this request has appropriate experience in the management of patients with migraine headaches

**Approvals subject to ALL of the criteria below being met (mark boxes and complete blanks as applicable):**

**A.** ☐ The patient has attained and maintained a minimum reduction of **at least 50%** in the average number of migraine days per month (calculated over the past 3 months) compared to baseline

**Please complete rows 1 and 2 for all renewals**

| | Date Average Calculated (YYYY / MM) | Average number migraine days/month (Please note: <, >, ranges or headache (HA) days are not accepted) |
|---|---|---|
| 1. Pre-CGRP antagonist | | Pre-treatment |
| | | |
| 2. First renewal: 6 months<br>Second and subsequent renewals: 1 year | | Renewal |
| | | |

**B. ADDITIONAL COMMENTS**

***Report all adverse events to the post-market surveillance program, Canadian Vigilance, toll-free 1-866-234-2345 (health professionals only).***

Personal information on this form is collected under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act* 22(1) and *Freedom of Information and Protection of Privacy Act* 26 (a),(c),(e). The information is being collected for the purposes of (a) administering the PharmaCare program, (b) analyzing, planning and evaluating the Special Authority and other Ministry programs and (c) to manage and plan for the health system generally. If you have any questions about the collection of this information, call Health Insurance BC from Vancouver at 1-604-683-7151 or from elsewhere in BC toll free at 1-800-663-7100 and ask to consult a pharmacist concerning the Special Authority process.

I have discussed with the patient that the purpose of releasing their information to PharmaCare is to obtain Special Authority for prescription coverage and for the purposes set out here.

_____
Prescriber's Signature (Mandatory)

***PharmaCare may request additional documentation to support this Special Authority request.***
***Actual reimbursement is subject to the rules of a patient's PharmaCare plan, including any annual deductible requirement, and to any other applicable PharmaCare pricing policy.***

## PHARMACARE USE ONLY

| Status | Effective Date (YYYY / MM / DD) | Duration of Approval |
|---|---|---|
| | | |

Save Print Clear Form