

☐ INITIAL

Complete sections 1 – 4

☐ RENEWAL

Complete sections 1 – 3, & 5

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

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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.

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.

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.

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

<input type="radio"/> fremanezumab 225 mg/1.5 mL 225 mg SC once monthly or 675 mg SC every 3 months	9901-0395	<input type="radio"/> galcanezumab 120 mg/mL 240 mg SC as a single loading dose, followed by 120 mg SC once monthly	9901-0424
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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 calculated over the past 3 months (*at the time of initial request for CGRP-antagonist coverage)

Date Average Calculated (YYYY / MM)	Average number migraine days/month

- 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. Please note: Injectable prophylactic medications are not accepted

Name of Medication Tried	Dose and Frequency	Duration of Trial	Reason for Discontinuation	Provide Details of Intolerances
			<input type="radio"/> Inadequate response <input type="radio"/> Intolerance(s): details →	
			<input type="radio"/> Inadequate response <input type="radio"/> Intolerance(s): details →	
			<input type="radio"/> Inadequate response <input type="radio"/> Intolerance(s): details →	
			<input type="radio"/> Inadequate response <input type="radio"/> Intolerance(s): details →	
			<input type="radio"/> Inadequate response <input type="radio"/> Intolerance(s): details →	

Please complete additional information on page 2 >>

Patient (Family) Name	Patient (Given) Name(s)	Personal Health Number (PHN)
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SECTION 5 – 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
1. Pre-CGRP antagonist		Pre-treatment
2. First renewal: 6 months 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).

<p>Personal information on this form is collected under the authority of, and in accordance with, the <i>British Columbia Pharmaceutical Services Act</i> 22(1) and <i>Freedom of Information and Protection of Privacy Act</i> 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.</p>	<p>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.</p> <p>_____ Prescriber's Signature (Mandatory)</p>
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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
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