ALBERTA BLUE CROSS®

FREMANEZUMAB
For Migraine Prevention
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

PATIENT INFORMATION				COVERAGE TYPE
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
ADDRESS			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
CITY, PROVINCE	PHONE		FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Please provide the following information for ALL requests

1) Diagnosis

☐ CHRONIC migraine defined as experiencing headaches for at least 15 days per month for more than three months of which at least eight days per month of this period are with migraine

☐ EPISODIC migraine defined as experiencing headaches for less than 15 days per month for more than three months of which at least four days per month of this period are with migraine

☐ Other (specify) _____

2) Dose and frequency requested

3) Combination therapy Will the requested drug be used in combination with onabotulinumtoxinA for the prevention of migraine?	☐ YES	☐ NO
4) The requesting physician has appropriate experience in the management of patients with migraine headaches	☐ YES	☐ NO

Section I: Please provide <u>pre-treatment</u> information for NEW requests for treatment-naïve and treatment-experienced patients

1) Pre-treatment average number of migraine days per month _____ Date _____

2) Previous medications utilized

Has the patient been refractory or intolerant to at least TWO **<u>ORAL</u>** prophylactic migraine medications of different classes?

☐ YES (please **SPECIFY** below)

	Please **SPECIFY** the medication	Please **SPECIFY** the dose, duration and response
Medication #1		
Medication #2		

☐ NO, provide reasons why oral prophylactic migraine medications cannot be tried

_____

Section II: Complete the following for all RENEWAL requests and INITIAL requests for treatment experienced patients

1) Current average number of migraine days per month _____ Date _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

FREMANEZUMAB
For Migraine Prevention
SPECIAL AUTHORIZATION CRITERIA

Criteria for coverage

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

FREMANEZUMAB (e.g. Ajovy) special authorization criteria

"Special authorization coverage may be provided for the prevention of episodic or chronic migraine in adult patients (18 years of age or older) who at baseline are refractory or intolerant to at least TWO oral prophylactic migraine medications of different classes.

'Episodic migraine' is defined as experiencing headaches for less than 15 days per month for more than three months of which at least four days per month of this period are with migraine.

'Chronic migraine' is defined as experiencing headaches for at least 15 days per month for more than three months of which at least eight days per month of this period are with migraine.

'Refractory' is defined as lack of effect in reducing the frequency of migraine days.

'Intolerant' is defined as demonstrating serious adverse effects to treatments as defined in product monographs.

Only one Drug Product of an anti-calcitonin gene related peptide or onabotulinumtoxinA for the prevention of migraine would be allowed for coverage at a time.

For coverage, the patient should be under the care of a physician who has appropriate experience in the management of patients with migraine headaches.
- Initial coverage may be approved for 225 mg every month or 675 mg every 3 months for a period of 6 months.
- For initial coverage, the baseline number of migraine days per month must be provided.
- Patients will be limited to receiving a one-dose supply of fremanezumab per prescription at their pharmacy.

For continued coverage beyond 6 months the patient must meet the following criteria:
1) The patient must be assessed by the physician after the initial 6 months of therapy to determine response.
2) The physician must confirm in writing, that the patient is a 'responder' that meets the following criteria:
    - Reduction of at least 50% in the average number of migraine days per month compared to baseline.

Following this assessment, continued coverage may be approved for 225 mg every month or 675 mg every 3 months for a period of 6 months. Ongoing coverage may be considered if the patient is re-assessed by the physician every 6 months, and is confirmed to be continuing to respond to therapy by maintaining a reduction of at least 50% in the average number of migraine days per month compared to baseline."