Drug Prior Authorization Form
Migraine
Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab), Qulipta (atogepant), Vyepti (eptinezumab)

The purpose of this form is to obtain information required to assess your drug claim.

IMPORTANT: Please answer all questions. Your claim assessment will be delayed if this form is incomplete or contains errors.

Any costs incurred for the completion of this form are the responsibility of the plan member/patient.

Canada Life recognizes and respects the importance of privacy. Personal information collected is used for the purposes of assessing eligibility for this drug and for administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about Canada Life's personal information policies and practices (including with respect to service providers), refer to www.canadalife.com or write to Canada Life's Chief Compliance Officer.

I authorize Canada Life, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or patient support programs or other benefits programs, other organizations, or service providers working with Canada Life or any of the above, located inside or outside Canada, to exchange personal information when relevant and necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I acknowledge that the personal information is needed to assess eligibility for this drug and to administer the group benefits plan. I acknowledge that providing consent will help Canada Life to assess my claim and that refusing to consent may result in delay or denial of my claim. Canada Life reserves the right to audit the information provided on this form at any time and this consent extends to any audit of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information and for Canada Life to use and disclose it as set out above.

I certify that the information given below is true, correct, and complete to the best of my knowledge. Failure to provide true, correct and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.

Plan Member's signature: _____ Date: _____

Form Completion Instructions:

1. **Complete "Patient Information" sections.**
2. **Have the prescribing physician complete the "Physician Information" sections.**
3. **Send all pages of the completed form to us by mail, fax or email as noted below.**

Note: As email is not a secure medium, any person with concerns about their prior authorization form/medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

Mail to: **The Canada Life Assurance Company**
Drug Claims Management
PO Box 6000
Winnipeg MB R3C 3A5

Fax to: **The Canada Life Assurance Company**
Fax 1-204-946-7664
Attention: Drug Claims Management

Email to: **cldrug.services@canadalife.com**
Attention: Drug Claims Management

For additional information regarding Prior Authorization and Health Case Management, please visit our Canada Life website at www.canadalife.com or contact Group Customer Contact Services at 1-800-957-9777. Deaf or hard of hearing and require access to a telecommunications relay service? Please contact us at 711 for TTY to Voice or 1-800-855-0511 for Voice to TTY.

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Patient Information
Migraine
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Plan Member Information – Complete all sections of this page (please print)

Plan Member:	Patient Name:	
Plan Name:	Plan Number:	Plan Member ID Number:
Patient Date of Birth (DD/MM/YYYY):	Address (number, street, city, province, postal code):	

Please indicate preferred contact number and if there are any times when telephone contact with you about your claim would be most convenient.

May we contact you by email? (Note that some correspondence may still need to be sent by regular mail).

☐ Yes ☐ No If yes, please provide email address: _____

Tell us if you have been on this drug before

Is the patient currently on, or previously been on this drug? ☐ Yes ☐ No

If Yes, a) indicate start date (DD/MM/YYYY): _____

b) coverage provided by: _____

(if coverage is not provided by Canada Life please provide pharmacy print-out showing purchase of this drug)

Tell us if you have coverage with any other benefits plan

Does the patient have drug coverage under any other group benefits plan? ☐ Yes ☐ No

If Yes, name of other Insurance Company: _____

If other plan is with Canada Life, tell us the plan and ID number: _____

Name of plan member: _____

Relationship to patient: _____

Provide details and attach documentation of acceptance or decline:

_____

_____

Tell us about any Provincial or other coverage you may have

Does the patient have coverage under a provincial program or from any other source? ☐ Yes ☐ No

If Yes, name of program or other source: _____

Provide details and attach documentation of acceptance or decline: _____

Is the patient currently receiving disability benefits for the condition for which this drug has been prescribed? ☐ Yes ☐ No

Tell us about any Patient Support Program you might be enrolled in

Has the patient enrolled in the patient support program for this drug? ☐ Yes ☐ No

If Yes, please provide the following information:

1. Patient support program patient ID Number: _____
2. Patient support program contact person name and phone number:

   Contact Name: _____ Phone Number: _____

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Physician Information
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Note to Physician: In order to assess a patient's claim for this drug, we require detailed information on the patient's prescription drug history as requested below.

Attach extra information if necessary. *GENETIC TEST RESULTS ARE NOT REQUIRED*

Physician's Information (please print)

Name of prescribing physician:

Specialty:

Address (number, street, city, province, postal code):

Telephone Number (including area code):	Fax Number (including area code):

1. Prescribed drug, dosage and regimen:

Drug	Dose and Regimen
☐ Aimovig	☐ 70mg once monthly ☐ 140mg once monthly
☐ Ajovy	☐ 225mg once monthly ☐ 675mg every 3 months
☐ Emgality	☐ 240mg loading dose, then 120mg monthly ☐ 300mg at onset, then monthly
☐ Qulipta	☐ 10mg once daily ☐ 30mg once daily ☐ 60mg once daily
☐ Vyepti	☐ 100mg every 3 months ☐ 300mg every 3 months

☐ Other (please specify): _____

Provide rationale: _____

2. Health Canada Indication (include date of initial diagnosis) (MM/YYYY): _____

☐ Cluster Headache, episodic

☐ Migraine Prevention

Complete questions 1-6 and Physician's information.

☐ Other (approved by Health Canada): _____

Complete questions 1-6 and Other condition (Health Canada approved).

☐ Other (prescribed use is not approved by Health Canada): _____

Complete questions 1-6 and Off-label use.

3. What is the anticipated duration of treatment with this drug? _____

4. Where will treatment be administered? ☐ Home ☐ Physician's Office ☐ Private clinic ☐ Hospital in-patient ☐ Hospital out-patient

5. Please provide medical rationale why this drug has been prescribed instead of an alternate drug in the same therapeutic class:

_____

_____

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Physician's Information *(continued)* (please print)

6. Drug and Treatment History – **must be completed for every request.** If coverage for these drugs was not provided by Canada Life, please submit a pharmacy printout for the last 12 months.

Drug(s) and Treatment(s) past and present	Dosing Regimen	Start Date (DD/MM/YYYY)	End Date (DD/MM/YYYY)	Clinical Results/Outcome
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:

Cluster Headache, Episodic - Emgality only

Does patient have a prior history of a cluster period lasting at least 6 weeks? ☐ Yes ☐ No

Has the patient experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least 3 months?

☐ Yes ☐ No

Will treatment with Emgality be discontinued at the end of a cluster period and during the remission time? ☐ Yes ☐ No

Will Emgality be used with other CGRP antagonists? ☐ Yes ☐ No

Renewal Request

Does the patient have a diagnosis of episodic cluster headache? ☐ Yes ☐ No

Has the patient experienced a positive response to therapy, demonstrated by a reduction in headache frequency or intensity? ☐ Yes ☐ No

Has the patient failed, is intolerant or contraindicated to one or more conventional preventative therapies (either verapamil or lithium)? ☐ Yes ☐ No

Please ensure the Drug and Treatment History chart is completed including time frame medications were used and clinical result/outcome.

Migraine Prevention

Patient has a diagnosis of: ☐ Episodic migraines ☐ Chronic Migraines

Please indicate the average number of migraine days per month in the last 12 months: _____

Has the patient received a minimum 12-week trial of 2 or more prophylactic medications from different pharmacological classes? ☐ Yes ☐ No

If coverage for these drugs was not provided by Canada Life, please submit a pharmacy printout for the last 12 months.

Please ensure the Drug and Treatment History chart is completed including time frame medications were used and clinical result/outcome.

Note combination treatment with botulinum toxin or other CGRP antagonists will not be considered.

Renewal Request

Has the patient experienced a reduction in migraine attack frequency or number of days with headache per month by 50% or more since initiating treatment? ☐ Yes ☐ No

Please state the average number of migraine days per month in the past 6 months: _____ days per month

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Physician's Information *(continued)* (please print)

Other condition (Health Canada approved)

Please provide any relevant information related to the disease and attach supporting documentation.

Off-label use

Questions 1 - 6 must be completed.

Date of initial diagnosis (DD/MM/YYYY): _____

Is there clinical evidence supporting the off-label use of this drug? ☐ Yes ☐ No

Provide clinical literature/studies to support the request for off-label use, such as:

- At least two Phase II or two Phase III clinical trials showing consistent results of efficacy; and
- Published recommendations in evidence-based guidelines supporting its use.

Provide medical rationale why this drug has been prescribed off-label instead of an alternate drug with an approved indication for this condition.

Provide any pertinent medical history or information to support this off-label request.

If this is a renewal request, provide documentation showing treatment efficacy since previous request.

Note for Physician: To be eligible for reimbursement, Canada Life may require your patient to purchase a drug requiring prior authorization from a pharmacy designated by Canada Life. If applicable, a health case manager will contact you with further information.

I certify that the information provided is true, correct, and complete.

Physician's Signature: _____ Date: _____

License Number: _____

It is important to provide the requested information in detail to help avoid delay in assessing claims for the above drug. This form may be subject to audit. The completed form can be returned to Canada Life by mail, fax, or email.

Note: As email is not a secure medium, any person with concerns about their prior authorization form/medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

Mail to: **The Canada Life Assurance Company**
Drug Claims Management
PO Box 6000
Winnipeg MB R3C 3A5

Fax to: **The Canada Life Assurance Company**
Fax 1-204-946-7664
Attention: Drug Claims Management

Email to: **cldrug.services@canadalife.com**
Attention: Drug Claims Management