SPECIAL AUTHORIZATION REQUEST FORM

The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage of biologics for Migraine

Pharmaceutical Services
Department of Health and Community Services
P.O. Box 8700, Confederation Bldg.
St. John's, NL A1B 4J6

Phone: (709) 729-6507
Toll Free Line: 1-888-222-0533
Fax: (709) 729-2851

Patient Information

Patient Name	Date of Birth	NLPDP Drug Card/MCP Number

Address

Drug Requested

☐ Atogepant (**Qulipta**) ☐ Eptinezumab (**Vyepti**) ☐ Fremanezumab (**Ajovy**) ☐ Galcanezumab (**Emgality**)

Diagnosis

☐ CHRONIC migraine defined as experiencing headache for at least 15 days per month for more three months of which at least 8 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 migraines.

☐ Other

Dose and frequency requested:

The requesting physician has experience in the management of patients with migraine: ☐ Yes ☐ No

Please provide pre-treatment information for NEW requests for treatment naïve and treatment-experienced patients

1. **Pre-treatment average number of migraines days per month:_____ Date:_____**
   Pre-treatment average number of headache days per month:_____ Date:_____

2. **Previous medications utilized:**
   Has the patient been refractory or intolerant to at least TWO oral 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 TWO oral prophylactic medications cannot be tried:_____**

Please complete for ALL RENEWAL requests and INITIAL requests for treatment experienced

Current average number of migraines days per month_____ Date:_____
Current average number of headache days per month_____ Date:_____

Additional Information:

Prescriber Information/Requested: ☐ Physician ☐ Other Healthcare Professional
Prescriber Name: _____ License Number: _____ Phone Number: _____
Address: _____ Fax Number: _____
Signature: _____ Date: _____

Pharmacy Name: (optional)_____ Pharmacy Name:_____
Date:_____