Prior Authorization Request Form: Chronic Migraine

Plan Member/Patient: Please complete pages 1 and 2 and have your physician complete pages 3 and 4. Completion of this form is not a guarantee of approval. All costs incurred to complete this form are the plan member's responsibility.

PART 1: INFORMATION TO BE COMPLETED BY THE PATIENT

Plan Member Name:	Patient Name:
Plan Member Date of Birth (YYYY/MM/DD):	Patient Date of Birth (YYYY/MM/DD):
Plan Sponsor/Employer: OpenCircle Benefit Plan	If you (the patient) are someone other than the covered member, please indicate your relation to the covered member: □ Spouse □ Dependant
Policy/Plan Number: 55400	
Certificate Number:	

Patient Address: _____ _____ _____ _____ _____
Number Street City Province Postal Code

Patient Email: _____ Patient Phone Number: _____

PART 2: CONSENT TO COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

As of the date hereof, I hereby authorize any person or organization who has personal health information about me, including any health care professional (which includes but is not limited to physicians, medical specialists, physiotherapists, pharmacists or any other person who has examined or treated me), health care institution, pharmacy patient support program, and other medical-related facility, Alberta Netcare, and any authorized agent of mine to release and disclose to Well and Truly RX Alberta Incorporated ("Well and Truly") the company provides prior authorization drug assessment services on behalf of the OpenCircle Benefit Plan, any personal information regarding my past medical history and current medical condition, including any relevant clinical notes (collectively, the "Personal Health Information"), which may be required to adjudicate the Request for Prior Authorization to which this Consent forms a part (the "Request").

I understand and agree that Well and Truly will keep any Personal Health Information obtained from such persons, organizations and/or agents secure and confidential and in accordance with applicable legislation and that my Personal Health Information will not be shared with any other party.

I authorize Well and Truly to collect, use and maintain my personal information, such as name, address, email address, and the Personal Health Information it deems necessary, for the purposes of adjudicating the Request or any purposes in any way ancillary thereto. I further authorize Well & Truly to contact me directly for the purposes of adjudicating the Request.

I authorize Well and Truly to collect, use and disclose my personal information in accordance with its Privacy Policy located at: https://wellandtrulyrx.ca/privacy-policy/

I hereby acknowledge and understand that:

- access to and use of my Personal Information will be limited to Well and Truly pharmacists and other Well and Truly employees in the course of their employment;
- by filling out the Request, I am not guaranteed approval for any level of coverage;
- Well and Truly has been engaged for the purpose of ensuring that criteria for the approval of claims are satisfied before approval is granted, and to ensure that the criteria for coverage are implemented consistently;
- Well and Truly has no interest, financial or otherwise, in the decision rendered in adjudicating the Request;
- Well and Truly specifically assumes no responsibility for the completeness or accuracy of any Personal Information which may be provided to Well and Truly in connection with the Request, and Well and Truly disclaims all liability for any loss or damage suffered by any person, including (without limitation) me, as a result of the processing or outcome of the Request; and
- I have no claim against Well and Truly for any loss or damage (direct, indirect, incidental, consequential or otherwise) I may suffer as a result of the handling, processing or outcome of the Request.

I understand and agree to the terms above *(If patient is <18 years old, parent/guardian to sign below).*

_____	_____	_____
Patient Full Name (please print)	Patient Signature	Date Signed (YYYY/MM/DD)

FOR PATIENTS OVER THE AGE OF 65 OR THOSE RESIDING IN BC, MB, AND SK:
Certain drugs require prior approval from Provincial or Pharmacare Programs before they are eligible for coverage.

ALL INITIAL AND RENEWAL SUBMISSIONS FOR PROVINCIALLY ELIGIBLE DRUGS MUST BE SUBMITTED TO THE PROVINCIAL PLAN FIRST. PLEASE ATTACH THE PROVINCIAL PLAN'S COVERAGE DECISION WITH THIS SUBMISSION.

PART 3: CO-ORDINATION OF BENEFITS

Are you currently on, or have previously been on this medication? □ Yes □ No	If yes, start date: (YYYY/MM/DD): _____ Coverage provided by: _____ ***A history of claims from pharmacy records demonstrating previous use is required***
Do you or your dependants have health benefits coverage through another health benefits company or insurance company? □ Yes □ No	If yes, name of other health benefits company/insurance company: _____ Policy/Plan Number: _____ Certificate Number: _____ Name of person holding coverage: _____

Are you currently receiving disability benefits (short-term or long-term) for the condition for which this medication has been prescribed?
□ Yes □ No

Have you applied for coverage or received any financial support for this medication:

From another insurance plan? □ Yes □ No	If yes, name of covered family member: _____ Relationship: _____ Name of insurance company: _____ Please provide details including coinsurance and any applicable maximums: _____ ***Please attach documentation of acceptance or declination.***
From a provincial program? □ Yes □ No	If yes, name of provincial program(s): _____ ***Please attach documentation of acceptance or declination.***
From a patient assistance/compassionate care program? □ Yes □ No	If yes, name of program(s): _____ Patient Assistance Program ID Number: _____ Patient Assistance Program Contact Name: _____ Patient Assistance Program Contact Information: _____

Please note, obtaining a compassionate (bridge) dose without prior authorization approval does not secure coverage.

PART 4: CURRENT/PAST PHARMACY INFORMATION

Please provide contact details of the pharmacy/pharmacies from which the patient has received medications over the last two years.

Pharmacy Name	Location (Street and City)	Phone Number

OpenCircle BENEFITS

Prior Authorization Request Form: Chronic Migraine

Prescribing Physician: Please provide information on your patient's medical condition/drug history.

PART 1: PRESCRIBER INFORMATION

Physician Name:	
Speciality:	Registration Number:
Address:	
Fax Number: _____ *(required)*	Phone Number: _____

PART 2: CLINICAL INFORMATION

Diagnosis:
□ Chronic Migraine □ Other: _____

Please note:

1. **The administration of Botulinum Toxin for cosmetic purposes, including the use of DINs labelled cosmetic or aesthetic, is strictly excluded from coverage.**
2. **There is currently a lack of published randomized controlled trial evidence to support the combination use of Botulinum Toxin and CGRP antagonists, hence combination therapy with the above agents will not be reimbursed.**

Date of Initial Diagnosis (MM/YYYY):	Anticipated duration of treatment (*Maximum approval is one year before renewal is required)*:	
Relevant drug allergies and nature of the reaction(s):	Headache Impact Test (HIT-6): _____ Date (MM/YYYY): _____	
Number of headache days per month in the previous 3 months: _____ /month _____ /month _____ /month	Average duration of continuous headaches (hours):	Number of headache days per month that are migraine headaches:

PART 3: REQUIRED PROPHYLACTIC THERAPIES

An adequate trial of three (3) medications that have been shown to prevent migraines must be documented before specialty therapies can be reimbursed. An adequate trial constitutes three (3) months of therapy with a given agent. Medications for acute treatment of migraines will not be accepted as prophylactic therapies.

Medication Name	Therapeutic Class Accepted for Migraine Prophylaxis	Dose	Start Date (MM/YYYY)	End Date (MM/YYYY)	Outcome *(Please provide details of intolerance, therapeutic failure, or contraindication)*
	Beta Blocker				
	TCA				
	SNRI				
	CCB				
	ACEI				
	ARB				
	Anticonvulsant				
	Other				

PART 4: PREVIOUS SPECIALTY THERAPIES

Medication Name	Therapeutic Class	Dose	Start Date (MM/YYYY)	End Date (MM/YYYY)	Outcome *(Please provide details of intolerance, therapeutic failure, or contraindication)*
	Botulinum Toxin				
	CGRP Antagonist				
	Other				

PART 5: MEDICATION REQUESTED

First Tier Specialty Therapy

OnabotulinumtoxinA:
□ Botox

Second Tier Specialty Therapy

Erenumab:
□ Aimovig 70 mg
□ Aimovig 140 mg

Fremanezumab:
□ Ajovy

Galcanezumab:
□ Emgality

Other:
_____

Please Note: Stepwise reimbursement applies, where a trial of first tier therapy is required before later tiers of therapy are reimbursed, as indicated here.

Directions for Use (i.e. prescription sig):

Where will treatment be administered? □ Home □ Physician's Office □ Private Clinic □ Hospital (Inpatient) □ Hospital (Outpatient)

Name of Facility: _____ Address: _____

PART 6: RENEWAL REQUEST

Please note for Botox renewal requests:

1. Patients who have not obtained an adequate treatment response after 3 treatment cycles will be discontinued from further therapy.
2. Patients who obtain an adequate response after 3 treatment cycles will be permitted to continue therapy for an additional 12 months if headache frequency remains ≥10 days per month.
3. For patients who achieve fewer than 10 headache days per month for 3 consecutive months, dosing frequency will be reassessed upon renewal.

Headache Impact Test (HIT-6):

Current: _____ Baseline: _____

Date (MM/YYYY): _____ Date (MM/YYYY): _____

Number of headache days per month in the previous 3 months:

_____/month _____/month _____/month

Average number of headache days per month prior to treatment:

ADDITIONAL INFORMATION

Please attach all relevant clinical information to support medical necessity of medication therapy requested, including any contraindications to relevant medications, as well as relevant lab tests which may support choice of medication therapy or renewal thereof.

Please be advised further information may be requested if needed to facilitate determination of coverage.

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

_____ _____

Prescribing Physician's Signature Date Signed (YYYY/MM/DD)

Please submit the completed form to OpenCircle Benefits by:

Fax: 780-455-6068 or **E-mail:** pa@opencirclebenefits.ca

Questions? Please call OpenCircle at 780-455-5845 (Edmonton) or 1-877-263-7266 (toll-free)