Medical Standards & Research Pre-approval Form

This is a pre-requisite form provided upon request for the drug **Galcanezumab**.

Kindly fill in all the requested information given below. This is a mandatory step to proceed further. Failure to provide information relevant to approval will delay the processing of the applicant's request. The provider will be contacted in case further clarifications are required.

GENERAL INFORMATION

- Member's Name:
- Member Card #:
- Policy:
- Age:
- Gender: ☐ Female ☐ Male
- Date: / /202_

PROVIDER INFORMATION

- Provider's Name:
- Ordering Clinician (ID # & Name):
- Performing Provider Name:
- Performing Clinician Specialty (ID # & Name):
- Referring Physician (ID # & Name):

SERVICE REQUESTED

- Principal/ Primary Diagnosis:
- ICD-10:
- Requested Drug and Dose:
- Number of episodes per month:
- Initial Dose: ☐ Refill ☐
- Quantity requested:

ADDITIONAL REQUIRED INFORMATION

- Documentation of beneficial response (for example, reduction in monthly migraine days or hours or reduction in days (please attach):
- ICHD-3 Classification criteria fulfilled? ☐ Yes ☐ No