Nova Scotia Provincial Pharmacare Programs

Request for Coverage of Agents for Migraine Prevention

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

REQUESTED DRUG

☐ Fremanezumab (Ajovy)	☐ Galcanezumab (Emgality)	☐ Eptinezumab (Vyepti)	☐ Atogepant (Qulipta)* *Insured for episodic migraine only.

REQUEST FOR INITIAL COVERAGE

Diagnosis:

For the treatment of patients with a diagnosis of:

☐ Episodic migraine, defined as migraine headaches on at least 4 days per month and less than 15 headache days per month for more than 3 months.

OR

☐ Chronic migraine, defined as headaches for at least 15 days per month for more than 3 months of which at least eight days per month are with migraine.

Baseline number of migraine days per month: ____________ Date: _________

Medications Tried (must be from two different classes):

Drug name, duration, and outcome. Please include details with respect to any intolerance or contraindication.

1.) ______________________________

2.) ______________________________

Initial Renewal Request:

Proof of beneficial clinical effect, defined as a reduction of at least 50% in the average number of migraine days per month at the time of first renewal compared with baseline.

Average number of migraine days per month: _______ Date: ______

Subsequent Renewal Requests:

Proof that the initial 50% reduction in the average number of migraine days per month has been maintained.

Average number of migraine days per month: _______ Date: ______

Additional Comments:

PRESCRIBER NAME & ADDRESS:

LICENCE # ____________ PRESCRIBER SIGNATURE ____________ DATE ____________

If you need assistance, please contact the Pharmacare Office at (902) 496-7001 or 1-800-305-5026

Please Return Form To: Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1; Fax: (902) 496-4440

01/2024

NOVA SCOTIA