

Market Applicability														
Market	DC	FL & FHK	FL MMA	FL LTC	GA	KS	KY	MD	NJ	NV	NY	TN	TX	WA
Applicable	X	X	NA	NA	X	NA	X	X	X	X	X	NA	NA	X

*FHK- Florida Healthy Kids

Emgality (galcanezumab)

Override(s)	Approval Duration
Prior Authorization	Initial request: 3 months Renewal requests: 1 year

Medications	Quantity Limit
Emgality (galcanezumab)	1 prefilled pen/syringe per 30 days*

*Initiation of therapy: May approve one additional prefilled pen/prefilled syringe in the first month of therapy.

APPROVAL CRITERIA

Initial requests for Emgality (galcanezumab) may be approved when the following criteria are met:

- I. Individual has a diagnosis of one of the following:
 - A. Episodic migraine defined as at least 4 and fewer than 15 migraine days per month and fewer than 15 headache days per month on average during the previous 3 month period; **OR**
 - B. Chronic migraine defined as a headache occurring on 15 or more days per month for more than 3 months, which, on at least 8 days per month, has features of a migraine headache (ICHD-3 beta);

AND

- II. Individual is using for prophylaxis of migraine headaches at a frequency of 4 or more migraine days per month;

AND

- III. Individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to two agents for migraine prophylaxis* (at least one agent in any two of the following classes) or has a contraindication to all of the following medications (AAN/AHA 2012/2015, Level A and B evidence; ICSI 2013, high quality evidence):
 - A. The following antidepressants: amitriptyline, venlafaxine; **OR**

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- B. One of the following beta blockers: Metoprolol, propranolol, timolol (oral), nadolol, atenolol, nebivolol; **OR**
- C. The following calcium channel blocker: verapamil; **OR**
- D. One of the following antiepileptic agents: valproate sodium, divalproex sodium, topiramate, gabapentin; **OR**
- E. Botox (for chronic migraine).

*Agents for migraine prophylaxis – May require Prior Authorization

Renewal requests for Emgality (galcanezumab) may be approved when the following criteria are met:

- I. Individual has a reduction in the overall number of migraine days or reduction in number of severe migraine days per month; **AND**
- II. Individual has obtained clinical benefit deemed significant by individual or prescriber.

State Specific Mandates		
State name	Date effective	Mandate details (including specific bill if applicable)
N/A	N/A	N/A

Key References:

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Applicable	X	X	NA	NA	X	NA	X	X	X	X	X	NA	NA	X

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