Manitoba

Ajovy / Fremanezumab

EXCEPTION DRUG STATUS (EDS) REQUEST FORM

FAX: (204) 942-2030 or 1-877-208-3588

Prescriber Name:	**Fax Number:** **Phone Number:**
Prescriber Address:	**Prescriber License Number (NOT Billing Number):**

Patient's First Name:	**PHIN:**	**MH Registration Number:**
Patient's Last Name:	**Patient's Date of Birth:**	
Requested Medication Name and Strength:	**Expected Dosing:**	**Expected Therapy Duration:**

Exception Drug Status (EDS) approval is granted only upon demonstration that the patient meets the specified EDS criteria. Please provide the following details to support the meeting of EDS criteria by the patient.

Diagnosis/Indication:	_____

Patient's Baseline Information (Prior to Treatment Initiation)

The patient is under the care of a physician who has appropriate experience in the management of migraine headaches.

☐ **YES** ☐ **NO**

Has the patient been experiencing headaches for more than 3 months? ☐ **YES** ☐ **NO**

Baseline total number of headaches experienced by the patient per month: _____

Of the total number of headaches experienced by the patient per month, please indicate the total number of *migraine* days experienced by the patient per month: _____

Patient's Drug History

Please indicate all previous and current oral prophylactic migraine medications tried by the patient:

Drug Name	Dose and Frequency	Treatment Start Date	Treatment Discontinuation Date	Number of Migraines/Month prior to Treatment	Number of Migraines/Month at Treatment Discontinuation	If treatment intolerance or contraindication, please describe.

Post-Treatment Information – For RENEWAL Assessment (Complete for EDS Renewal ONLY)

Average total number of migraine days per month after initiation of Ajovy: _____

Prescriber Signature and Date:

Date:		**Prescriber Signature:**	