AmeriHealth Caritas New Hampshire

Cymbalta® (Duloxetine)

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information			
Prescriber last name:		Prescriber first name:	
Prescriber address:		Prescriber representative:	
Specialty:		NPI number:	
Phone #:	Fax #:		

Clinical history

1. Does the patient have a diagnosis of major depressive disorder? ☐ Yes ☐ No
If YES to question 1, please proceed to Section IV (Non-Preferred Drug Approval Criteria)

2. Does the patient have a diagnosis of generalized anxiety disorder? ☐ Yes ☐ No

3. Does the patient have a diagnosis of diabetic peripheral neuropathy? ☐ Yes ☐ No
If YES to question 3, has the patient experienced a treatment failure, or is not a candidate for treatment with at least ONE of the following agents: any tricyclic antidepressant or gabapentin? List treatment failure and dates:

4. Does the patient have a diagnosis of fibromyalgia? If YES, continue to question 5–10. ☐ Yes ☐ No

5. Has widespread pain been present for at least 3 months? ☐ Yes ☐ No

6. Is pain present in at least 11 out of the 18 specific tender points (according to ACR guidelines)? ☐ Yes ☐ No

7. Please describe any physical fitness interventions that have been done. If additional space is needed, please use another page.

8. Has the patient experienced a treatment failure, or is not a candidate for treatment with at least ONE of the following agents: amitriptyline or cyclobenzaprine?
☐ Yes ☐ No
List treatment failure, maximum doses failed, and dates:

9. Does the patient have a diagnosis of chronic musculoskeletal pain? ☐ Yes ☐ No
Please describe:

If YES to question 9, has the patient experienced a treatment failure, or is not a candidate for treatment with acetaminophen, an NSAID, and cyclooxygenase 2 inhibitors?

10. Is the patient currently on pregabalin or milnacipran? ☐ Yes ☐ No

11. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

If you are requesting Cymbalta® for a diagnosis of major depressive disorder proceed.

Non-preferred drug approval criteria

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

☐ Allergic reaction. Describe reaction:

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Non-preferred drug approval criteria
☐ Drug-to-drug reaction. Describe reaction:
☐ Previous episode of an unacceptable side effect or therapeutic failure. Provide clinical information:
☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Provide clinical information:
☐ Age specific indications. Provide patient age and explain:
☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Explain and provide a reference:

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.