AmeriHealth Caritas™
New Hampshire

Fibromyalgia

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:
NPI number:	Specialty:
Phone #:	Fax #:

Clinical history
1. Does the patient have a diagnosis of fibromyalgia? ☐ Yes ☐ No
2. Has widespread pain been present for at least 3 months? ☐ Yes ☐ No
3. Is pain present in at least 11 out of the 18 specific tender points (according to ACR guidelines)? ☐ Yes ☐ No
4. Please describe any physical fitness interventions that have been done. If additional space is needed, please use another page.
5. 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 Please list treatment failure, maximum doses failed and dates:
6. Is the patient currently on pregabalin (Lyrica®), duloxetine (Cymbalta®), or milnacipran (Savella®)? ☐ Yes ☐ No (If yes, please note that concurrent therapy will only be approved for 30 days)
7. Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

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.