AmeriHealth Caritas New Hampshire

Lyrica®

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 partial onset seizures? (If yes, no additional questions need to be completed) ☐ Yes ☐ No
2. Does the patient have a diagnosis of post-herpetic neuralgia? ☐ Yes ☐ No
3. Does the patient have a diagnosis of diabetic peripheral neuropathy? ☐ Yes ☐ No
If yes to question(s) 2 or 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? ☐ Yes ☐ No Please describe treatment failure, provide the dosage used, and provide dates (use a separate sheet if additional space is required):
4. Does the patient have a diagnosis of fibromyalgia? (If yes, continue to question 5 – 9) ☐ 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 (use a separate sheet if additional space is required):
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 Please describe treatment failure and provide dates (use a separate sheet if additional space is required):
9. Is the patient currently on duloxetine or milnacipran? ☐ Yes ☐ No
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.