MedStar Medicare Choice

MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

LYRICA
Prior Authorization Form

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Lyrica (Pregablin)	□25mg □150mg □50mg □200mg □75mg □225mg □100mg □300mg			
□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Clinical Information

Diagnosis:	Date of Diagnosis:

Does patient have diabetic peripheral neuropathy? If yes, please provide a chart note that includes a diagnosis of diabetes or history of diabetic medication use, AND a trial of gabapentin.	□ Yes □ No
Does patient have post-herpetic neuralgia? If yes, a trial of gabapentin or a tricyclic antidepressant is required, please indicate in chart.	□ Yes □ No
Does patient have Fibromyalgia? Provide the following Chart Documentation: □ Diagnosis of fibromyalgia with history of widespread pain involving the extremities for three months and localized area of tenderness. □ Trial and failure of previous therapies such as gabapentin (dose of at least 1200mg/day), muscle relaxants and/or tricyclic antidepressants with dose, duration and rationale for failure, intolerance, or contraindication. □ Trial of exercise or physical therapy	□ Yes □ No

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Please indicate any drug trials			
Medication	**Dates of Therapy**	**Dose**	**Reason for Discontinuing**

Please provide any additional information which should be considered in the space below:

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