Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Lyrica® (Pregabalin)

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient at least 18 years of age?

☐ Yes ☐ No

Q2. Will Lyrica be used in conjunction with other agents (such as gabapentin) that have a chemical structure similar to Lyrica?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of neuropathic pain associated with diabetic peripheral neuropathy (DPN)?

☐ Yes ☐ No

Q4. Has the patient tried at least two (2) pharmacological treatments from the following formulary therapeutic classes or medications at maximum therapeutic doses? Please include documentation of agents used, with dose, dates/duration of use, and specific outcomes. a. Tricyclic antidepressants (such as amitriptyline, nortriptyline) b. Serotonin norepinephrine reuptake inhibitors (such as duloxetine, venlafaxine)

☐ Yes ☐ No

Q5. Does the patient have a diagnosis of postherpetic neuralgia (PHN)?

☐ Yes ☐ No

Q6. Has the patient tried tricyclic antidepressants (such as amitriptyline, nortriptyline) at maximum therapeutic doses? Please include documentation of agents used, with dose, dates/duration of use, and specific outcomes.

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q7. Does the patient have a diagnosis of Fibromyalgia according to American College of Rheumatology criteria, including symptoms present for at least 3 months?	
☐ Yes	☐ No
Q8. Has the patient been appropriately evaluated for other causes of pain consistent with a differential diagnosis to include but not limited to conditions such as rheumatoid arthritis, Sjögren's syndrome, systemic lupus erythematosus, ankylosing spondylitis, polymyalgia rheumatic, inflammatory myositis and metabolic myopathies, infection, hypothyroidism, other endocrine disorders, statin-associated myopathy, peripheral neuropathies, entrapment syndromes, and neurologic disorders?	
☐ Yes	☐ No
Q9. Has the patient had a history of therapeutic failure or a documented contraindication to non-pharmacologic therapies? (Examples of non-pharmacologic therapies include, but are not limited to, the following: physiotherapy, cognitive-behavioral therapy, aerobic exercise, hydrotherapy, strength training, or relaxation, etc.)	
☐ Yes	☐ No
Q10. Has the patient tried at least two (2) pharmacological treatments from the following formulary therapeutic classes or medications at maximum therapeutic doses? Please include documentation of agents used, with dose, dates/duration of use, and specific outcomes. a. Tricyclic antidepressants (such as amitriptyline, nortriptyline) b. Cyclobenzaprine c. Serotonin norepinephrine reuptake inhibitors (such as duloxetine, milnacipran, venlafaxine) d. Selective serotonin reuptake inhibitors (such as fluoxetine, paroxetine)	
☐ Yes	☐ No
Q11. Does the patient have a diagnosis of neuropathic pain associated with spinal cord injury?	
☐ Yes	☐ No
Q12. Has the patient tried and failed gabapentin at a minimum dose of at least 1,200 mg per day?	
☐ Yes	☐ No
Q13. Is Lyrica being prescribed as adjunctive therapy for an adult patient with partial onset seizures?	
☐ Yes	☐ No
Q14. Has the patient tried pharmacological treatment with at least (2) two formulary oral anticonvulsants (such as carbamazepine, gabapentin, lamotrigine, oxcarbazepine, levetiracetam, topiramate, valproate, zonisamide, phenytoin) at maximum therapeutic doses? Please include documentation of agents used, with dose, dates/duration of use, and specific outcomes.	
☐ Yes	☐ No
Q15. Is the requested dose for Lyrica within the package insert dosing parameters below? DPN: up to 300 mg per day PHN: up to 600 mg per day Fibromyalgia: up to 450 mg per day Adjunctive therapy for partial onset seizures: up to 600 mg per day Neuropathic pain associated with spinal cord injury: up to 600 mg per day	

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q16. Requested Duration: ☐ 12 Months	
Q17. Additional Information:	

Prescriber Signature _____ Date _____

Updated 2018