

LYRICA

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested: Lyrica (pregablin)	Strength Requested: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 75mg <input type="checkbox"/> 100mg <input type="checkbox"/> 150mg <input type="checkbox"/> 200mg <input type="checkbox"/> 225mg <input type="checkbox"/> 300mg	Frequency:	Qty Dispensed
<input type="checkbox"/> New Medication <input type="checkbox"/> Ongoing Medication	If Ongoing Provide Date Started:	If medication is ongoing, did the member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:			

MEDICAL HISTORY

Does patient have partial seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient have diabetic peripheral neuropathy? <input type="checkbox"/> Include previous therapies tried and failed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient have post-herpetic neuralgia? <input type="checkbox"/> Include previous therapies tried and failed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient have fibromyalgia? <input type="checkbox"/> Include copy of <u>chart documentation</u> showing the diagnosis of fibromyalgia with history of widespread pain involving the extremities for three months and localized area of tenderness. <input type="checkbox"/> Include copy of <u>chart documentation</u> showing previous therapies such as Gabapentin, Muscle Relaxants and Tricyclic Antidepressants tried and failed with dose, duration and rationale for failure <input type="checkbox"/> Include copy of <u>chart documentation</u> showing trial of exercise or physical therapy for fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No

HISTORY OF PREVIOUS MEDICATIONS USED TO TREAT THE ABOVE CONDITION

Medication Trial/ Previous Therapies	Date of Therapy		Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing
	Start Date	End Date			

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

