UnitedHealthcare Community Plan

Lyrica
PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: ________________
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: ________________

Section B - Physician Information				
First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information	
Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? ______________	

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information about this case, if any:

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

- What is the patient's diagnosis? (check all that apply)

□ Seizure Disorder	□ Neuropathic Pain Associated with Spinal Cord Injury
□ Fibromyalgia	□ Diabetic Peripheral Neuropathy
□ Post Herpetic Neuralgia	□ Other, list:

- Has the patient had a trial of gabapentin? □ Yes □ No □ N/A if prescribing for seizure disorder
If yes, complete Section D above with medication information (specific doses and trial dates are required)

Diagnosis of Seizure Disorder

- Has the patient previously had a trial of gabapentin? □ Yes □ No
If yes: - Complete Section D above with medication information (specific doses and trial dates are required)
- Will Lyrica be used as adjunctive therapy? □ Yes □ No

Diagnosis of Fibromyalgia

- Has the patient had an inadequate response or intolerance to treatment with any of the following? □ Yes □ No
Check all that apply & complete Section D with medication information (specific doses and trial dates are required)
- □ Tricyclic Antidepressant at a maximum tolerated dose
- □ Selective Serotonin Reuptake Inhibitor (SSRI) at a maximum tolerated dose
- □ Serotonin and Norepinephrine Reuptake Inhibitor (SNRI) at the maximum tolerated dose
- □ Cyclobenzaprine

Diagnosis of Diabetic Peripheral Neuropathy (DPN)

- Has the patient had an inadequate response or intolerance to treatment with any of the following? □ Yes □ No
Check all that apply & complete Section D with medication information (specific doses and trial dates are required)
- □ Tricyclic Antidepressant at a maximum tolerated dose, or had an intolerance
- □ Duloxetine

Diagnosis of Post Herpetic Neuralgia (PHN)

- Has the patient had an inadequate response or intolerance to a tricyclic antidepressant at the maximum tolerated dose? □ Yes □ No
If yes, complete Section D above with medication information (specific doses and trial dates are required)

Physician Signature: ________________________ **Date:** ____________

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