Lyrica Oral Solution (pregabalin)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM): _____** **WEIGHT (LB/KG): _____** **ALLERGIES: _____**

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Diabetic peripheral neuropathy □ Fibromyalgia □ Neuropathic pain associated with spinal cord injury □ Partial-onset seizures □ Postherpetic neuralgia □ Other diagnosis: _____ICD-10: _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Has the patient had a trial and an inadequate response or intolerance to Lyrica capsules? □ Yes □ No

Does the patient have difficulty swallowing tablets and capsules? □ Yes □ No
Please submit documentation.

Is the patient using any other oral tablets or capsules (excluding sprinkles capsules and orally dissolving tablets?
□ Yes □ No

For diagnosis of Diabetic peripheral neuropathy, also answer:
Has the patient had a trial and an inadequate response to a tricyclic antidepressant or anticonvulsant? □ Yes □ No
Please submit documentation.

For diagnosis of Fibromyalgia, also answer:
Is the patient currently taking any of the following medications? □ Yes □ No
If yes, please select:
- □ **Anticonvulsant**
- □ **Antidepressant**
- □ **Benzodiazepine**
- □ **Muscle relaxant**
- □ **Narcotic**
- □ **Oral corticosteroid**
- □ **Tramadol**

Does the patient have renal insufficiency? □ Yes □ No *Please submit documentation*

Does the patient have an unstable medical or psychiatric disorder? □ Yes □ No *Please submit documentation*

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For diagnosis of Neuropathic pain associated with a spinal cord injury, also answer:
Select the spinal cord injury that is associated with the patient's neuropathic pain:

- □ **Diving injury**
- □ **Injury due to physical trauma**
- □ **Injury secondary to removing a benign tumor**
- □ **Ischemic injury**
- □ **Paraplegia**
- □ **Quadriplegia**
- □ **Other:_____**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811