Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Lyrica (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Lyrica (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

LYRICA (pregabalin)

Other, Please specify: _____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of spinal cord injury or partial onset seizures? Y N

   [If yes, then skip to question 13.]

2. Does the patient have a diagnosis of post herpetic neuralgia? Y N

   [If no, then skip to question 5.]

3. Has the patient had an inadequate response with a 3 months trial of gabapentin at maximum tolerated doses? Y N

   [If yes, then skip to question 13.]

4. Has the patient experienced intolerable side effects with gabapentin? Y N

   [If yes, then skip to question 13.]

   [If no, then no further questions.]

5. Has the patient had an inadequate response with a 3 months trial of duloxetine at maximum tolerated doses? Y N

   [If yes, then skip to question 7.]

6. Has the patient experienced intolerable side effects with duloxetine? Y N

   [If no, then no further questions.]

7. Does the patient have a diagnosis of fibromyalgia? Y N

   [If no, then skip to question 10.]

8. Has the patient had an inadequate response with a 3 months trial of gabapentin or a tricyclic antidepressant (i.e., amitriptyline or nortriptyline) at a maximum tolerated dose? Y N

   If yes, list medication(s) tried:
   _____

   [If yes, then skip to question 13.]

9. Has the patient experienced intolerable side effects with gabapentin or a tricyclic antidepressant (i.e., amitriptyline or nortriptyline)? Y N

   If yes, list medication(s) tried:
   _____

   [If yes, then skip to question 13.]

   [If no, then no further questions.]

10. Does the patient have a diagnosis of diabetic or cancer related neuropathic pain? Y N

    [If no, then no further questions.]

11. Has the patient had an inadequate response with a 3 months trial of at least 1 additional formulary agent other than duloxetine such as topical capsaicin, tricyclic antidepressants, Y N

tramadol, venlafaxine, or gabapentin?

If yes, list medications(s) tried:
_____

[If yes, then skip to question 13.]

12. Has the patient experienced intolerable side effects with at least 1 additional formulary agent such as topical capsaicin, tricyclic antidepressants, tramadol, venlafaxine, or gabapentin? Y N

    If yes, list medication(s) tried:_____

    [If no, then no further questions.]

13. Is the patient 18 years of age or older? Y N

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature Date