



Prior Authorization Request Form – Lyrica (pregabalin)

Instructions:

This form is to be used by participating providers to request coverage for Lyrica (pregabalin). Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services
 P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
 Fax: 1-800-918-7542

A Lyrica (pregabalin) step therapy program has been developed to encourage the use of first-line therapies before Lyrica for the same indication. If approved, quantity limits apply.

First-line therapies:

gabapentin
 tricyclic antidepressants

Second-line therapy:

Lyrica (pregabalin)

Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)
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4. Prescriber's FULL Name & Specialty: (please include mailing address)	5. Contact Person at Office:
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6. Prescriber's FAX & Telephone Number: Fax: ()	Tel: ()
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7. Requested Drug:	8. Dose, Frequency, and Duration of Requested Drug:
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9. Diagnosis/Indication: <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Neuropathic pain <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Other (please specify if neuropathic in nature): _____

10. Has the member been started and stabilized on the requested drug for at least 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No - If 'yes', duration of therapy = _____
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11. Has the member previously tried the following?	
Drug Name (please check all that apply)	Response (please check all that apply)
<input type="checkbox"/> gabapentin	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> tricyclic antidepressant (Please specify): _____	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> other (Please specify): _____	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> other (Please specify): _____	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy

12. Prescriber comments:

Signature:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

 Prescriber's signature

 Date