Prior Authorization Form

CAREFIRST - DC EXCHANGE 5T

Lyrica, Gralise, Horizant Step Therapy (HMF)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-582-2022** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Lyrica, Gralise, Horizant Step Therapy (HMF).

Drug Name (select from list of drugs shown)
Pregabalin

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: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the patient experienced an inadequate treatment response, intolerance, or contraindication to immediate-release generic gabapentin?	Y N
[If yes, then no further questions.]	
2. Is this request for Horizant (gabapentin enacarbil)?	Y N
[If no, then skip to question 4.]	
3. Is Horizant (gabapentin enacarbil) being prescribed for the treatment of Restless Legs Syndrome?	Y N
[No further questions.]	

4.	Is this request for Lyrica (pregabalin)?	Y N
5.	Is Lyrica (pregabalin) being prescribed for one of the following: A) Management of fibromyalgia, B) Management of neuropathic pain associated with spinal cord injury?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date