



LYRICA® (Pregabalin)
New Hampshire Medicaid Prior Authorization Request Form



Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ____ / ____ / ____

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____	NH Medicaid Number: _____
Date of Birth: ____ / ____ / ____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Drug Name: _____	Strength: _____
Dosing Directions: _____	Length of Therapy: _____

Section II: Clinical History:

1. Does the patient have a diagnosis of partial onset seizures? (If yes, please go to section III)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the patient have a diagnosis of post-herpetic neuralgia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does the patient have a diagnosis of diabetic peripheral neuropathy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to question(s) #2 or #3, has the patient experienced a treatment failure, or is not a candidate for treatment with at least two of the following agents: any tricyclic antidepressant, gabapentin, topical lidocaine or tramadol?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please describe treatment failure, provide the dosage used, and provide dates (use a separate sheet if additional space is required):	

4. Does the patient have a diagnosis of fibromyalgia? (If yes, continue to question #5 - #9)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has widespread pain been present for at least 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is pain present in at least 11 out of the 18 specific tender points (according to ACR guidelines)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. On a separate sheet, please describe any physical fitness interventions that have been done.	
8. On a separate sheet please describe any behavioral health interventions.	
9. Has the patient experienced a treatment failure, or is not a candidate for, treatment with at least two of the following agents: amitriptyline, cyclobenzaprine or fluoxetine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please describe treatment failure and provide dates (use a separate sheet if additional space is required):	

10. Is the patient currently on duloxetine or milnacipran?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(If yes, please note that concurrent therapy will only be approved for 30 days)	
11. Is there any additional information that would help in the decision-making process? Use a separate sheet if additional space is required.	

Section III: Prescriber Information:

Name: _____	NPI Number: _____
Phone Number: (____) _____ - _____	Fax Number: (____) _____ - _____

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.

Signature of Prescribing Provider