All requests for Lyrica (pregabalin) a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

**Lyrica (pregabalin) Prior Authorization Criteria:**
For all requests for Lyrica (pregabalin) all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of fibromyalgia and the following criteria is met:

- Must provide documentation showing the member has tried and failed (for at least 3 months) or had an intolerance or contraindication to the following:
  - duloxetine

Coverage may be provided with a diagnosis of diabetic peripheral neuropathy (DPN) and the following criteria is met:

- The member is currently receiving treatment with an antidiabetic agent

Coverage may be provided with a diagnosis of neuropathic pain associated with spinal cord injury

Coverage may be provided with a diagnosis of partial onset seizure disorder and the following criteria is met:

- Member has tried and failed or has a documented intolerance or contraindication to two preferred anticonvulsants

Coverage may be provided with a diagnosis of postherpetic neuralgia (PHN) and the following criteria is met:

- Must provide documentation showing the member has a tried and failed (for at least 4 weeks) or had an intolerance or contraindication to the following:
  - gabapentin at a dose of 1800mg/day

- **Initial Duration of Approval:** 12 months.
- **Reauthorization criteria:**
  - Members with historical pharmacy claims data meeting the following criteria will receive automatic reauthorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data
cannot obtain the criteria below, documentation will be required to indicate the member meets the reauthorization criteria below. Claims will automatically adjudicate on-line, without a requirement to submit for reauthorization when the following criteria is met:

- Documentation the member has been on Lyrica (pregabalin) within the last 45 days

- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.
LYRICA (pregabalin)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including *any progress notes, laboratory test results, or chart documentation* as applicable to Health Options Pharmacy Services. **FAX:** 1-855-476-4158

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE:** 1-844-325-6251

**UPDATED:** 10/2018  
**DMMA APPROVED:** 10/2018

### PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Requesting Physician:</th>
<th>NPI:</th>
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<tbody>
<tr>
<td>Physician Specialty:</td>
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<tr>
<td>Office Address:</td>
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<tr>
<td>Office Contact:</td>
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<td>Office Phone:</td>
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<td>Office Fax:</td>
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### MEMBER INFORMATION

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Health Options ID:</th>
<th>DOB:</th>
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### DRUG INFORMATION

<table>
<thead>
<tr>
<th>Strength &amp; Frequency:</th>
<th>Duration:</th>
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<tbody>
<tr>
<td>Is the patient currently receiving requested medication?</td>
<td>Yes</td>
</tr>
<tr>
<td>Date Medication Initiated:</td>
<td></td>
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</table>

### MEDICAL HISTORY (Attach supporting clinical information with this form)

- **Diagnosis**
  - Fibromyalgia
  - Diabetic peripheral neuropathy
  - Is the member currently receiving treatment for diabetes with an antidiabetic agent? Yes [ ]  No [ ]

- Partial onset seizures
- Neuropathic pain associated with spinal cord injury
- Postherpetic neuralgia
- Other (please specify):

**How will the use of Lyrica affect the use of opioid therapy for this member?**

- Will not start opioid therapy
- Prevent an increase of current opioid therapy
- Cause a decrease in current opioid therapy

### PREVIOUS MEDICATIONS USED TO TREAT THE ABOVE DIAGNOSIS

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Strength/Frequency</th>
<th>Dates of Therapy</th>
<th>Status (Discontinued &amp; Why or Current)</th>
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### REAUTHORIZATION

Has the member been on this medication within the last 45 days Yes [ ]  No [ ]

### ADDITIONAL SUPPORTING INFORMATION or CLINICAL RATIONALE

<table>
<thead>
<tr>
<th>Prescribing Physician Signature</th>
<th>Date</th>
</tr>
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</table>