AmeriHealth

Prior Authorization Form

Lyrica®/Cymbalta®/Pristiq®/Savella®/Aplenzin®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)* ☐ **Lyrica®** ☐ **Cymbalta®** ☐ **Pristiq®** ☐ **Savella®** ☐ **Aplenzin®**

Date: _____ Patient ID#: _____ DOB: _____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

******MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE******

1. DIAGNOSIS FOR DRUG REQUESTED:

☐ Major depressive disorder ☐ Post-herpetic neuralgia ☐ Generalized Anxiety Disorder (GAD)

☐ Diabetic peripheral neuropathy (**please specify diabetic medications in the medication history)**

☐ Non-diabetic neuropathy ☐ Fibromyalgia ☐ Add-on therapy for partial onset epileptic seizures in adults

Other (*specify all*): _____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

☐ **N/A** If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration

3. PATIENT HISTORY:

Which of the following medications has the patient tried and failed? (check all that apply)

☐ **Prozac® (fluoxetine)** ☐ **Paxil® (paroxetine)** ☐ **Zoloft® (sertraline)** ☐ **Celexa® (citalopram)** ☐ **Luvox® (fluvoxamine)**
☐ **Wellbutrin® (bupropion)** ☐ **Wellbutrin SR® (bupropion SR)** ☐ **Wellbutrin XL® (bupropion XL)** ☐ **Tramadol**
☐ **Effexor® (venlafaxine)** ☐ **Effexor XR®** ☐ **Lexapro®** ☐ **Neurontin® (gabapentin)** ☐ **Carbamazepine**

If a patient has contraindication to any of the drugs listed in any of the 3 questions below, please note in the comment section

a. Has the patient tried any tricyclic antidepressants such as (amitriptyline, etc...)? ☐ Yes ☐ No ☐ N/A

b. Has the patient tried any opioid containing products? ☐ Yes ☐ No ☐ N/A

c. Has the patient tried Lidoderm® or other topical lidocaine? ☐ Yes ☐ No ☐ N/A

d. Has the patient been stabilized in an institutional setting? ☐ Yes ☐ No ☐ N/A

e. Is the patient currently stabilized for over 4 weeks? (*Provide dates in the Medication History Section)* ☐ Yes ☐ No ☐ N/A

f. Is this a request for continuous therapy? ☐ Yes ☐ No ☐ N/A

Please add any other supporting medical information that may be useful in the decision-making process:

_____

_____

_____

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only **Coverage effective date / /**

Document #_____ Processor Initials_____ Date_____

M F Rx coverage Y N STANDARD - SELECT LOB_____

Previous Auth Y N **Approved** **Reviewer Initials**_____ Date_____

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