CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Lyrica**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone #:		Provider Fax #:	Provider NPI #:
Patient Name:	CCHP Member ID #:	Patient DOB:	Patient Age:

Drug Requested: **Lyrica (pregablin)**	Strength: ☐ **25mg** ☐ **50mg** ☐ **75mg** ☐ **100mg** ☐ **50mg** ☐ **200mg** ☐ **225mg** ☐ **300mg**	Frequency:	Quantity Dispensed (including units):

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

New medication ☐ **Ongoing medication** ☐	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	☐ **Yes** ☐ **No**

Diagnosis:

Medical History

Does patient have partial seizures?	☐ **Yes** ☐ **No**
Does patient have diabetic peripheral neuropathy? *(Include previous therapies tried and failed)*	☐ **Yes** ☐ **No**
Does patient have post-herpetic neuralgia? (Include previous therapies tried and failed)	☐ **Yes** ☐ **No**
Does patient have neuropathy due to spinal cord injury? (Include previous therapies tried and failed)	☐ **Yes** ☐ **No**
Does patient have fibromyalgia?	☐ **Yes** ☐ **No**

Include copy of chart documentation showing the diagnosis of fibromyalgia with history of widespread pain involving the extremities for three months and localized area of tenderness.

Include copy of chart documentation showing previous therapies such as Gabapentin, Muscle Relaxants and Tricyclic Antidepressants tried and failed with dose, duration and rationale for failure. Include copy of chart documentation showing trial of exercise or physical therapy for fibromyalgia.

Please provide a history of medications previously tried and failed.

Medication Name	Date of Therapy		Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing
	Start Date	End Date			

Please provide any additional clinical information which should be considered in the space below: