

NEUROPATHIC PAIN AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Neuropathic Pain Agents** and **Quantity Limits/Daily Dose Limits** can be found on the Department's website, accessible at <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	
<input type="checkbox"/> Renewal request	PA#: _____	Prescriber name: _____	
Office contact name/phone #: _____		Specialty: _____	
LTC facility contact/phone: _____		State license #: _____	NPI: _____
RECIPIENT INFORMATION		Street address: _____	
Recipient Name: _____		Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____

CLINICAL INFORMATION

Non-preferred medication requested:			
<input type="checkbox"/> Cymbalta capsule	<input type="checkbox"/> gabapentin tablet	<input type="checkbox"/> Irenka DR 40 mg capsule	<input type="checkbox"/> Lyrica solution
<input type="checkbox"/> duloxetine DR 40 mg capsule	<input type="checkbox"/> Gralise tablet	<input type="checkbox"/> lidocaine patch	<input type="checkbox"/> Neurontin solution
<input type="checkbox"/> gabapentin solution	<input type="checkbox"/> Horizant tablet	<input type="checkbox"/> Lidoderm patch	<input type="checkbox"/> Neurontin capsule
			<input type="checkbox"/> Neurontin tablet
			<input type="checkbox"/> Qutenza patch
			<input type="checkbox"/> Savella tablet
Strength: _____	Directions: _____	Quantity: _____	Refills: _____
Diagnosis: _____		Dx code (required): _____	
Section A: Initial LIDODERM requests:			
1. Does the Recipient have a diagnosis of postherpetic neuralgia (pain due to shingles or Herpes Zoster infection)?		<input type="checkbox"/> Yes – <i>submit documentation of differential diagnosis</i>	
		<input type="checkbox"/> No – <i>submit medical literature supporting the use of the requested medication for the Recipient's diagnosis</i>	
2. Does the Recipient have a history of trial and failure, contraindication, or intolerance to all of the following: tricyclic antidepressants (TCAs), Lyrica, and gabapentin immediate-release (at least 1800 mg/day)?		<input type="checkbox"/> Yes – <i>submit documentation of drug regimen and treatment outcome</i>	
		<input type="checkbox"/> No	
Section B: Initial GRALISE requests:			
1. Does the Recipient have a diagnosis of postherpetic neuralgia (pain due to shingles or Herpes Zoster infection)?		<input type="checkbox"/> Yes – <i>submit documentation of differential diagnosis</i>	
		<input type="checkbox"/> No – <i>submit medical literature supporting the use of the requested medication for the Recipient's diagnosis</i>	
2. Does the Recipient have a history of trial and failure, contraindication, or intolerance to all of the following: tricyclic antidepressants (TCAs), Lyrica, and gabapentin immediate-release (at least 1800 mg/day)?		<input type="checkbox"/> Yes – <i>submit documentation of drug regimen and treatment outcome</i>	
		<input type="checkbox"/> No	
3. Does the Recipient have renal impairment?		<input type="checkbox"/> Yes – <i>submit documentation of SCr, CrCl, or GFR test results</i> <input type="checkbox"/> No	
Section C: Initial HORIZANT requests:			
1. What is the Recipient's diagnosis?		<input type="checkbox"/> postherpetic neuralgia (PHN) (pain due to shingles/herpes zoster) <i>Submit documentation of differential diagnosis</i>	
		<input type="checkbox"/> moderate to severe restless leg syndrome (RLS)	
2. Does the Recipient have renal impairment?		<input type="checkbox"/> Yes – <i>submit documentation of SCr, CrCl, or GFR test results</i> <input type="checkbox"/> No	
3. For a diagnosis of RLS , does the Recipient have a history of trial and failure, contraindication, or intolerance to any of the following medications? Check all that apply.		<input type="checkbox"/> Yes – <i>submit documentation of drug regimen and treatment outcome</i>	
<input type="checkbox"/> pramipexole (Mirapex)		<input type="checkbox"/> No	
<input type="checkbox"/> ropinirole (Requip)			
<input type="checkbox"/> gabapentin capsules (at least 1800 mg/day)			
4. For a diagnosis of PHN , does the Recipient have a history of trial and failure, contraindication, or intolerance to all of the following: tricyclic antidepressants (TCAs), Lyrica, and gabapentin immediate-release (at least 1800 mg/day)?		<input type="checkbox"/> Yes – <i>submit documentation of drug regimen and treatment outcome</i>	
		<input type="checkbox"/> No	
Section D: All other initial NON-PREFERRED requests			
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the following preferred agents?		<input type="checkbox"/> Yes – <i>submit documentation of drug regimen and treatment outcome</i>	
<input type="checkbox"/> capsaicin OTC		<input type="checkbox"/> No	
<input type="checkbox"/> duloxetine 20 mg, 30 mg, or 60 mg capsule			
<input type="checkbox"/> gabapentin capsule			
<input type="checkbox"/> Lyrica capsule			
Section E: All RENEWAL requests			
1. Has the Recipient experienced a positive clinical response since starting the requested medication?		<input type="checkbox"/> Yes – <i>submit documentation of treatment response</i>	
		<input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH REQUESTED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
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