



This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-800-357-9577**
If this an **URGENT** request, please call 1-800-417-8164

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI (required): _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Gralise 300mg | <input type="checkbox"/> Lyrica 100mg | <input type="checkbox"/> Neurontin 100mg |
| <input type="checkbox"/> Gralise 600mg | <input type="checkbox"/> Lyrica 150mg | <input type="checkbox"/> Neurontin 300mg |
| <input type="checkbox"/> Horizant 600mg | <input type="checkbox"/> Lyrica 200mg | <input type="checkbox"/> Neurontin 400mg |
| <input type="checkbox"/> Lyrica 25mg | <input type="checkbox"/> Lyrica 225mg | <input type="checkbox"/> Neurontin 600mg |
| <input type="checkbox"/> Lyrica 50mg | <input type="checkbox"/> Lyrica 300mg | <input type="checkbox"/> Neurontin 800mg |
| <input type="checkbox"/> Lyrica 75mg | | <input type="checkbox"/> Neurontin 250mg/5ml Solution |

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:

1. Is the patient currently taking the requested medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
2. Is the patient taking samples or paying 100% out of pocket for the medication being requested? If no, please indicate: <input type="checkbox"/> Requested medication covered under previous insurance plan <input type="checkbox"/> Started medication in hospital <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
3. Has the patient had a trial of gabapentin immediate release or Neurontin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
4. Has the patient had a trial of Horizant or Gralise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

<p>5. For the diagnosis of <u>Generalized Anxiety Disorder (GAD)</u>, has the patient tried at least two of the following: a TCA (e.g., imipramine, nortriptyline), an SSRI (e.g., paroxetine, Lexapro), an SNRI (e.g., Effexor XR), or buspirone?</p> <p>If yes, please list: _____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
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Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

Prescriber Signature: _____	Date: _____
Office Contact Name: _____	Phone Number: _____

Based upon each patient’s prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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