



**New Hampshire AIDS Drug Assistance Program  
Prior Authorization/Non-Preferred Drug Approval Form**

Lyrica®

DATE OF MEDICATION REQUEST:    /    /

**SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED**

LAST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATE OF BIRTH:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

GENDER:     Male     Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

**SECTION II: PRESCRIBER INFORMATION**

LAST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

SPECIALTY:

NPI NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PHONE NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FAX NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**SECTION III: CLINICAL HISTORY**

1. Does the patient have a diagnosis of partial onset seizures? (If yes and request is for generic, no additional questions need to be completed. If yes and request is for brand, go to Section IV.)     Yes     No
2. Does the patient have a diagnosis of post-herpetic neuralgia?     Yes     No
3. Does the patient have a diagnosis of diabetic peripheral neuropathy?     Yes     No
  - a. If yes to question 2 or 3, has the patient experienced a treatment failure, or is patient not a candidate for treatment with at least ONE of the following agents: any tricyclic antidepressant or gabapentin?     Yes     No
  - b. Please describe treatment failure, provide the dosage used, and provide dates (use a separate sheet if additional space is required):

(Form continued on next page.)



**New Hampshire AIDS Drug Assistance Program  
Prior Authorization/Non-Preferred Drug Approval Form**

Lyrica®

DATE OF MEDICATION REQUEST:     /     /

**PATIENT LAST NAME:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**PATIENT FIRST NAME:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**SECTION III: CLINICAL HISTORY (Continued)**

4. Does the patient have a diagnosis of fibromyalgia? (If yes, continue to questions 5–9.)  Yes  No
5. Has widespread pain been present for at least 3 months?  Yes  No
6. Is pain present in at least 11 out of the 18 specific tender points (according to ACR guidelines)?  Yes  No
7. Please describe any physical fitness interventions that have been done (use a separate sheet if additional space is required):
- \_\_\_\_\_
8. Has the patient experienced a treatment failure, or is not a candidate for, treatment with at least ONE of the following agents: amitriptyline or cyclobenzaprine?  Yes  No
- a. Please describe treatment failure and provide dates (use a separate sheet if additional space is required):
- \_\_\_\_\_
9. Is the patient currently on duloxetine or milnacipran?  Yes  No
10. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.
- \_\_\_\_\_

***If you are requesting brand Lyrica® or Lyrica CR®, proceed to Section IV.***

**SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA**

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

Allergic reaction. **Describe reaction:**

\_\_\_\_\_

Drug-to-drug interaction. **Describe reaction:**

\_\_\_\_\_

*(Form continued on next page.)*



**New Hampshire AIDS Drug Assistance Program  
Prior Authorization/Non-Preferred Drug Approval Form**

Lyrica®

DATE OF MEDICATION REQUEST:    /    /

**PATIENT LAST NAME:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**PATIENT FIRST NAME:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA (Continued)**

- Previous episode of an unacceptable side effect or therapeutic failure. **Provide clinical information:**  
\_\_\_\_\_
- Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. **Provide clinical information:**  
\_\_\_\_\_
- Age specific indications. **Provide patient age and explain:**  
\_\_\_\_\_
- Unique clinical indication supported by FDA approval or peer reviewed literature. **Explain and provide a reference:**  
\_\_\_\_\_
- Unacceptable clinical risk associated with therapeutic change. **Please explain:**  
\_\_\_\_\_

**I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.**

**PRESCRIBER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_