Reset Form Print Form

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form

Pregabalin

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.)

Magellan Rx MANAGEMENT℠

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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.)

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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**: _____

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