Updated: 05/2018
PARP Approved: 05/2018

Gateway Health
Prior Authorization Criteria
Lyrica (pregabalin)

All requests for Lyrica (pregabalin) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Lyrica (pregabalin) Prior Authorization Criteria:

For all requests for Lyrica (pregabalin) all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of fibromyalgia and the following criteria is met:

- Must provide documentation showing the member has tried and failed (for at least 3 months) or had an intolerance or contraindication to:
    - Duloxetine

Coverage may be provided with a diagnosis of diabetic peripheral neuropathy (DPN) and the following criteria is met:

- The member is currently receiving treatment with an antidiabetic agent

Coverage may be provided with a diagnosis of neuropathic pain associated with spinal cord injury

Coverage may be provided with a diagnosis of partial onset seizure disorder

Coverage may be provided with a diagnosis of postherpetic neuralgia (PHN) and the following criteria is met:

- Must provide documentation showing the member has a tried and failed (for at least 4 weeks) or had an intolerance or contraindication to the following:
    - gabapentin at a dose of 1800mg/day

- **Initial Duration of Approval:** 12 months.
- **Reauthorization criteria**:
    - Documentation demonstrating treatment with Lyrica has provided improvement in the member's condition.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or

peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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LYRICA (PREGABALIN) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health[SM] Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Frequency:	Duration:	
Is the member currently receiving requested medication? ☐ Yes ☐ No		Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis

☐ Fibromyalgia

☐ Diabetic peripheral neuropathy
- Is the member currently receiving treatment for diabetes with an antidiabetic agent? ☐ Yes ☐ No

☐ Partial onset seizures

☐ Neuropathic pain associated with spinal cord injury

☐ Postherpetic neuralgia

☐ Other (please specify):

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Did the member show improvement while on therapy? ☐ Yes ☐ No

Please describe the response:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date