



Updated: 07/2019
DMMA Approved: 07/2019

Request for Prior Authorization for Gralise (gabapentin)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Gralise (gabapentin) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Gralise (gabapentin) Prior Authorization Criteria:

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

- Must have documentation of an adequate trial and failure (of at least 4 weeks) of immediate-release (IR) gabapentin defined as either failure due to insufficient response despite doses up to 1,800mg/day OR evidence of failure due to an intolerance
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial 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.

**Gralise (gabapentin)
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.

PHONE: (844) 325-6253 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:
Health Options ID:	Member weight: _____ pounds or _____ kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Medication Initiated:
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: Postherpetic neuralgia (PHN) Other: _____

Has the member tried immediate-release (IR) gabapentin at a dose of at least 1800mg per day for at least 4 weeks Yes No

Status (Discontinued & Why/ Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature

Date

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