Updated: 08/2020
DMMA Approved: 08/2020

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.

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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) 325-6251 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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