Updated: 09/2022
DMMA Approved: 09/2022

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

All requests for Lyrica (pregabalin)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 the following:
  - 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**:
    - Members with historical pharmacy claims data meeting the following criteria will receive automatic reauthorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the reauthorization criteria below. Claims will automatically adjudicate on-line, without a requirement to submit for reauthorization when the following criteria is met:
        - Documentation the member has been on Lyrica (pregabalin) within the last 45 days

- **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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

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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 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 8:00 am to 7:00 pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Patient Name:	DOB:	
Health Options ID:	Member weight:	Height:

DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the patient 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 (Attach supporting clinical information with this form)

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):

PREVIOUS MEDICATIONS USED TO TREAT THE ABOVE DIAGNOSIS

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

REAUTHORIZATION

Has the member been on this medication within the last 45 days ☐ Yes ☐ No

ADDITIONAL SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Physician Signature	Date

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