Prior Authorization Request Form for Neuropathic Pain Agent

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Directions:	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request:	Dx/Dx Code: _____
For Controlled Substance Neuropathic Pain Agents, did the prescriber or prescriber's delegate search the PDMP to review the member's controlled substance prescription history before issuing this prescription for the requested agent?	☐ Yes ☐ No
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Neuropathic Pain Agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No Medications Previously Taken (start and end date and dose):_____ [redacted]

Therapeutic Duplication:
If concurrently prescribed a therapeutic duplicate (i.e. gabapentinoid different from the agent being requested):
- ☐ Member is transitioned from one gabapentinoid to another with the intent of discontinuing one of the medications
- ☐ Member has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines

Exceeds Quantity Limit:
- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

CHECK ALL THAT APPLY. *SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.*

REQUEST FOR GRALISE (GABAPENTIN ER):
- ☐ Documented history of therapeutic failure, contraindication or intolerance to both of the following: (medication, start date and end date)
  - ☐ Tricyclic Antidepressant:_____
  - ☐ Gabapentin regular-release (titrated to 1800mg/day):_____

REQUEST FOR HORIZANT (GABAPENTIN ENACARBIL):
- ☐ For postherpetic neuralgia, documented history of therapeutic failure, contraindication or intolerance to both of the following: (medication, start date and end date)
  - ☐ Tricyclic Antidepressant:_____
  - ☐ Gabapentin regular-release (titrated to 1800mg/day):_____
- ☐ For moderate-to-severe primary restless leg syndrome, documented history of therapeutic failure, contraindication or intolerance to both of the following: (medication, start date and end date)
  - ☐ Gabapentin regular-release (titrated to 1800mg/day):_____

☐ Pramipexole or Ropinirole:_____

FOR RENEWAL REQUESTS:

Member has documentation of tolerability and experienced a positive clinical response to requested medication evidenced by:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)