

Complete Patient and Physician information (PLEASE PRINT)

STEP
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI Number:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP
2

Diagnosis	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Postherpetic Neuralgia <input type="checkbox"/> Diabetic Peripheral Neuropathy <input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Other (please state): _____ _____ _____
Clinical Consideration	<input type="checkbox"/> Previous trial of Neurontin(gabapentin) (if indicated for postherpetic neuralgia) <i>-For indications of epilepsy, fibromyalgia, and diabetic peripheral neuropathy, a previous trial of gabapentin is NOT required for approval of Lyrica therapy.</i> -This PA only applies to Medicaid. Private Pay & Medicare claims for Lyrica do not require prior trial of gabapentin.	
	<input type="checkbox"/> Previous or current trial of <u>any</u> anticonvulsant Please indicate which anticonvulsant:	
Supporting Documentation	Diagnosis: ICD-9/10 Code #/ Description / J Code (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Lyrica® (pregabalin)	
	Strength _____ Sig _____ Qty _____ Refills _____	
	<p><i>*Please attach all relevant medical records and test results*</i></p> <p>We will not process incomplete forms.</p> <p>If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.</p>	

STEP
3

I certify that the above is correct and accurate to the best of my knowledge and that the form is complete. (please sign and date)

Prescriber Signature

Date

STEP
4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk: 970-248-5034

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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