

**Complete Patient and Physician information (PLEASE PRINT)**

STEP 1	Member Name:	Physician Name:
	Address:	Address:
	Member ID:	Phone #:
	Member DOB:	Fax #:

**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> <b>-This PA only applies to Medicaid. Private Pay&amp; Medicare claims for Lyrica do not require prior trial of gabapentin.</b>	
	Supporting Documentation	<input type="checkbox"/> Previous or current trial of <u>any</u> anticonvulsant Please indicate which anticonvulsant: _____  Diagnosis: ICD-9 Code #/ Description (required): _____  Please attach a copy of the prescription or provide ALL of the information below: Lyrica® (pregabalin) Strength _____ Sig _____ Qty _____ Refills _____  Please attach all relevant medical records and test results. <b>Incomplete forms will not be processed.</b>	

STEP 3 **I certify that the above is correct and accurate to the best of my knowledge (please sign and date).**

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

STEP 4 **Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:  
970-248-5034**

Pharmacy Technician initials \_\_\_\_\_ Date Initiated \_\_\_\_\_

**Confidentiality Notice:**

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