HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
LYRICA® CR

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Lyrica® CR (pregabalin extended-release)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is the member 18 years of age or older?	☐	☐	
2. Does the member have a documented diagnosis of peripheral neuropathy, post-herpetic neuralgia (PHN), fibromyalgia, and/or neuropathic pain with spinal cord injury?	☐	☐	**Please provide documentation**
3. Has the member had a 3-month trial and failure, intolerance, or contraindication to gabapentin?	☐	☐	**Please provide documentation**
4. Has the member had a 3-month trial and failure, intolerance, or contraindication to a tricyclic antidepressant or duloxetine?	☐	☐	**Please provide documentation**
5. Has the member had a 3-month trial and failure, intolerance, or contraindication to generic pregabalin?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated clinical documentation show a continued medical need for therapy?	☐	☐	**Please provide documentation**
3. Does updated clinical documentation show the therapy has been effective and tolerable?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- 116
Origination Date: 01/27/2021
Reviewed/Revised Date: 01/27/2021
Next Review Date: 01/27/2022
Current Effective Date: 02/01/2021