

## Lyrica - Nebraska Prior Authorization Request Form

Please complete this <u>entire</u> form and fax it to: 866-940-7328. If you have questions, please call 800-310-6826. This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Inforn		low at ica	13t 24 110ui 3	TOT TOVICW.					
First Name:	Last Name:				Member ID:				
Address:									
City:	State:			ZIP Code:					
Phone:	DOB:			Allergies:					
Primary Insurance Information	(if any):	,			I				
Is the requested medication	on: □ New or □	Continuati	on of Thera	oy? If continuation, I	ist staı	rt date:			
Is this patient currently he	ospitalized?	Yes □ No	If recently d	lischarged, list discl	narge o	date:			
Section B - Provider Inforr	mation								
First Name:			Last Name:				M.D./D.O.		
Address:			City:				ZIP code:		
Phone:	Phone: Fax:			NPI #: Spe			pecialty:		
Office Contact Name / Fax atte	ention to:								
Section C - Medical Inform	nation								
Medication:						Strength:			
Directions for use:						Quantity:			
Diagnosis (Please be specific & provide as much information as possible):							CD-10 CODE:		
	·		,						
Is this member pregnant?	Yes □ No	If yes,	what is this m	nember's due date?					
Section D - Previous Medi	cation Trials								
Medication Name	Strength	Dire	Directions Dates of Therap		y Reason for failure / discontinuation				
Section E – Additional info	ormation and Ex	planation	of why prefe	rred medications wo	uld no	t meet the	patient's needs:		
Please refer	to the patient's	PDL at ww	w.uhcprovid	ler.com for a list of p	referre	ed alterna	tives		



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Member First name:		Member Last name:	Member DOB:				
Clinical and Drug Specific Information							
ALL REQUESTS							
□ Yes □ No	Does the patient have any of the following diagnoses? (If yes, check which applies)  Seizure Disorder  Neuropathic Pain Associated with Spinal Cord Injury  Fibromyalgia  Diabetic Peripheral Neuropathy (DPN)  Post Herpetic Neuralgia (PHN)						
□ Yes □ No	Does the patient have history of failure, contraindication or intolerance to gabapentin (generic Neurontin) at a minimum dose of 1800 mg daily for <u>4 weeks</u> ? (If yes, complete section D above)						
LYRICA CR – DPN AND PHN							
□ Yes □ No	Does the patient have history of failure, contraindication, or intolerance to Lyrica immediate release capsules or suspension? (If yes, complete section D above)						
Provider Signature: Date:							

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