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Chronic Pain Syndromes Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for pregabalin (Lyrica®) and milnacipran (Savella™). These drugs will be considered for their FDA indication(s) and other conditions as listed in the compendia. Requests for doses above the manufacturer recommended dose will not be considered. The trial examples below are not an all inclusive list. Please refer to the Preferred Drug List (PDL) located at www.iowamedicaidpdl.com for a complete list of preferred drugs in these therapeutic classes. For patients with a chronic pain diagnosis who are currently taking opioids, as seen in pharmacy claims, a plan to decrease and/or discontinue the opioid(s) must be provided with the initial request. Initial authorization will be given for three months. Requests for renewal must include an updated opioid treatment plan and documentation of improvement in symptoms and quality of life. Requests for non-preferred brand drugs, when there is a preferred A-rated bioequivalent generic product available, are also subject to the selected brand name prior authorization criteria and must be included with this request. Payment will be considered under the following conditions:

Preferred (no PA required within quantity limit)
☐ Duloxetine

Nonpreferred
☐ Cymbalta ☐ Lyrica ☐ Savella

Preferred (PA required)

☐ Pregabalin

☐ **Fibromyalgia (*Lyrica® or Savella™)*: a** diagnosis of fibromyalgia with the following documented trials:

a. A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following preferred generic agents: tricyclic antidepressant (amitriptyline, nortriptyline) or SNRI (duloxetine, venlafaxine er).

Gabapentin trial

Dose: _____Trial start date: _____ Trial end date: _____

Reason for failure: _____

Preferred drug trial #2

Name/dose: _____Trial start date: _____ Trial end date: _____

Reason for failure: _____

b. Documented nonpharmacologic therapies (such as cognitive behavior therapies, exercise, etc,)

Nonpharmacological treatments tried: _____

☐ **Post-herpetic neuralgia (*Lyrica®*):** a diagnosis of post-herpetic neuralgia with the following documented trials:

A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant (amitriptyline, nortriptyline), topical lidocaine, or valproate. .

Gabapentin trial

Dose: _____Trial start date: _____ Trial end date: _____

Reason for failure: _____

Preferred drug trial #2

Name/dose: _____Trial start date: _____ Trial end date: _____

Reason for failure: _____

☐ **Diabetic peripheral neuropathy (duloxetine *or Lyrica®*):** a diagnosis of diabetic peripheral neuropathy with the following documented trials:

A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant (amitriptyline, nortriptyline) or duloxetine.

Gabapentin trial

Dose: _____Trial start date: _____Trial end date: _____

Reason for failure: _____

Preferred drug trial #2

Name/dose: _____Trial start date: _____ Trial end date: _____

Reason for failure: _____

☐ **Partial onset seizures, as adjunct therapy (*Lyrica®*)**

☐ **Neuropathic pain associated with spinal cord injury (*Lyrica®*)**

☐ **Other diagnosis of use:** _____

Must complete for chronic pain diagnosis:

Initial requests:

Does the member have current opioid use? ☐ Yes Name/dose:_____ ☐ No

If yes, provide specific plan, including time line, to decrease and/or discontinue opioid use: _____

Renewal Requests:

Does the member have current opioid use? ☐ Yes Name/dose:_____ ☐ No

If yes, provide updated opioid treatment plan: _____

_____

Document improvement in symptoms and quality of life: _____

_____

Other relevant information: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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