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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Neurontin (gabapentin)

Prior Authorization of Benefits Form

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341 .

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**
Neurontin (gabapentin)	_____	_____	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.)

□ Yes	□ No	Is the request for a dose less than or equal to 1,400 mg per day?
□ Yes	□ No	Does the patient have a diagnosis of chronic kidney disease in the last 365 days?
□ Yes	□ No	Does the patient have a dialysis CPT code in the last 180 days?
□ Yes	□ No	Does the patient have a diagnosis of epilepsy/convulsions, neuropathic pain, migraine, restless leg syndrome or fibromyalgia in the last 730 days?
□ Yes	□ No	Does the patient have a history of an inferred migraine agent in the last 90 days?
□ Yes	□ No	Is there additional medical information that justifies the use of the medication? If Yes, please indicate the additional medical information that justifies the use of the medication: _____ _____

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.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

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