pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

NEUROPATHIC PAIN AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Neuropathic Pain Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # pages: _____	Prescriber name:	
Office contact name/phone #:		Specialty:	
LTC facility contact/phone:		State license #:	NPI:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐Cymbalta capsule ☐Horizant tablet ☐Neurontin capsule ☐Qutenza patch
☐duloxetine DR 40 mg capsule ☐Lidoderm patch ☐Neurontin solution ☐Savella dose pack
☐gabapentin solution ☐Lyrica solution ☐Neurontin tablet ☐ _____
☐Gralise tablet ☐Lyrica CR tablet

Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Dx code (required):	

QUTENZA requests: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreens Specialty

Initial GRALISE requests	
1. Does the beneficiary have a diagnosis of postherpetic neuralgia (pain due to shingles or Herpes Zoster infection)?	☐Yes – *Submit documentation of differential diagnosis.* ☐No – *Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.*
2. Does the beneficiary have a history of trial and failure, contraindication, or intolerance to all of the following: tricyclic antidepressants (TCAs), Lyrica, and gabapentin immediate-release (at least 1800 mg/day)?	☐Yes – *Submit documentation of drug regimen and treatment outcome.* ☐No
3. Does the beneficiary have renal impairment?	☐Yes – *Submit documentation of SCr, CrCl, or GFR test results.* ☐No

Initial HORIZANT requests	
1. What is the beneficiary's diagnosis?	☐postherpetic neuralgia (PHN) (pain due to shingles/herpes zoster) ☐moderate to severe restless leg syndrome (RLS) *Submit documentation of differential diagnosis.*
2. Does the beneficiary have renal impairment?	☐Yes – *Submit documentation of SCr, CrCl, or GFR test results.* ☐No
3. ***For a diagnosis of RLS***, does the beneficiary have a history of trial and failure, contraindication, or intolerance to any of the following medications? Check all that apply. ☐pramipexole (Mirapex) ☐ropinirole (Requip) ☐gabapentin capsule/tablet (at least 1800 mg/day)	☐Yes – *Submit documentation of drug regimen and treatment outcome.* ☐No
4. ***For a diagnosis of PHN***, does the beneficiary have a history of trial and failure, contraindication, or intolerance to all of the following: tricyclic antidepressants (TCAs), Lyrica, and gabapentin immediate-release (at least 1800 mg/day)?	☐Yes – *Submit documentation of drug regimen and treatment outcome.* ☐No

All other initial NON-PREFERRED requests	
1. Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the following preferred agents? ☐capsaicin cream OTC ☐gabapentin capsule or tablet ☐Lyrica capsule ☐duloxetine 20 mg, 30 mg, or 60 mg capsule ☐lidocaine 5% patch ☐Savella tablet	☐Yes – *Submit documentation of drug regimen and treatment outcome.* ☐No

All RENEWAL requests	
1. Did the beneficiary experience a positive clinical response since starting the requested medication?	☐Yes – *Submit documentation of treatment response.* ☐No

PLEASE FAX COMPLETED FORM WITH REQUESTED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: