

TRICARE Prior Authorization Request Form for  
gabapentin enacarbil (**Horizant**)



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HEALTHCARE

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**FAX Completed Form and  
Applicable Progress Notes to:  
(410) 424-4037**

## USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**Questions?** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

**Step 1** Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

**Step 2** Please complete the clinical assessment:

1. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Has the patient tried and failed gabapentin or pregabalin at maximally tolerated dose?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. What is the patient's diagnosis or indication?	<input type="checkbox"/> Post herpetic neuralgia – Proceed to question 4 <input type="checkbox"/> Restless leg syndrome – Proceed to question 5 <input type="checkbox"/> Other – <b>STOP</b> Coverage not approved	
4. Does the patient have a contraindication to, intolerability to or has tried and failed a tricyclic antidepressant (TCA) (for example: amitriptyline, amoxapine, desipramine) at maximally tolerated dose?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
5. Does the patient have a contraindication to, intolerability to or has tried and failed pramipexole or rotigotine at maximally tolerated dose?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

_____	_____
Prescriber Signature	Date

[28 December 2022]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#: