

TRICARE Prior Authorization Request Form for
gabapentin ER 24 hr tablets (**Gralise**)



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MEDICINE

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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 STOP Coverage not approved |
| 2. What is the patient's diagnosis or indication? | <input type="checkbox"/> Post herpetic neuralgia – Proceed to question 3 <input type="checkbox"/> Other – STOP Coverage not approved | |
| 3. Has the patient tried and failed gabapentin or pregabalin at maximally tolerated dose? | <input type="checkbox"/> Yes Proceed to question 4 | <input type="checkbox"/> No STOP 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 STOP 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#: |