



<b>Prior Authorization</b>
<p><b>JOHNS HOPKINS HEALTHCARE (MEDICAID)</b>          Lyrica CR - Priority Partners MCO</p> <p>This fax machine is located in a secure location as required by HIPAA regulations.          Complete/review information, sign and date. Fax signed forms to Johns Hopkins Healthcare at <b>1-410-424-4607</b>.          Please contact Johns Hopkins Healthcare at <b>1-888-819-1043</b> with questions regarding the Prior Authorization process.</p> <p>When conditions are met, we will authorize the coverage of Lyrica CR - Priority Partners MCO.</p>

Drug Name (select from list of drugs shown) Lyrica CR (pregabalin extended-release)
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Quantity	Frequency	Strength	
Route of Administration	Expected Length of Therapy		

<b>Patient Information</b>	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

<b>Prescribing Physician</b>	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

<b>Diagnosis:</b> _____	<b>ICD Code:</b> _____
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Comments: _____
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<b>Please circle the appropriate answer for each question.</b>	
1. Is this request for continuation of therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N
<p>[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]</p> <p>[If no, then skip to question 3.]</p>	
2. Is the patient showing clinical improvement from treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	

[No further questions.]	
3. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
4. Does the patient have the diagnosis of neuropathic pain associated with diabetic peripheral neuropathy?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If yes, then skip to question 6.]	
5. Does the patient have the diagnosis of postherpetic neuralgia?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
6. Has the patient tried and failed at least two medications commonly used to treat the identified diagnosis?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

<b>Prescriber (Or Authorized) Signature and Date</b>