

Prior Authorization Request Form for
Gralise (gabapentin) and **Horizant** (gabapentin enacarbil ER)



JOHNS HOPKINS
 MEDICINE

JOHNS HOPKINS
 HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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

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. Has the patient experienced an adverse event with gabapentin immediate-release (IR) that is not expected to occur with the requested medication?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 2
2. Does the patient have a contraindication to gabapentin IR that is not expected to exist with the requested medication?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 3
3. Is there a clinical reason why the patient cannot use gabapentin IR?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved

4. What is the clinical reason that gabapentin IR cannot be used?

Sign and date below

Step 3 I certify the above is true to the best of my knowledge.

Please sign and date:

 Prescriber Signature

 Date

[29 November 2019]

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#:
Date Faxed to MD:	Date Decision Rendered: