DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Lyrica® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Diabetic peripheral neuropathy (DPN)
❑ Fibromyalgia
❑ Neuropathic pain associated with postherpetic neuralgia (PHN)
❑ Neuropathic pain associated with spinal cord injury
❑ Partial onset seizure
❑ Radiculopathy
❑ Trigeminal neuralgia
❑ Other diagnosis: ____________________________________ ICD-10 Code(s): _________________________________

Clinical information:
Will the patient receive concomitant gabapentin therapy with Lyrica? ❑ **Yes** ❑ **No**

For Lyrica solution requests, also answer the following:
Does the patient have a diagnosis which confirms a difficulty in swallowing? ❑ **Yes** ❑ **No**

Diabetic peripheral neuropathy, fibromyalgia, neuropathic pain associated with postherpetic neuralgia, and trigeminal neuralgia:
Has the patient had a trial and failure, contraindication, or intolerance to a tricyclic antidepressant **OR** an immediate-release gabapentin? ❑ **Yes** ❑ **No**

Partial onset seizure:
Is Lyrica being used as adjunctive therapy? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following:
Is there documentation of positive clinical response to Lyrica therapy? ❑ **Yes** ❑ **No**
Will the patient receive concomitant gabapentin therapy with Lyrica? ❑ **Yes** ❑ **No**

For Lyrica solution requests, also answer the following:
Does the patient have a diagnosis which confirms a difficulty in swallowing? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity requested per DAY? ________
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: ____

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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