



Prior Authorization Form

Lyrica®/Pristiq®/Savella®/Aplenzin®/Gralise®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) [] Lyrica® [] Pristiq® [] Savella® [] Aplenzin® [] Gralise®
Date: _____ Patient ID#: _____ DOB: _____
Patient Name: _____ Provider NPI: _____
Prescribing Physician: _____ Office Contact: _____
Office Fax #: _____ Office Phone: _____

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MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE

1. DIAGNOSIS FOR DRUG REQUESTED:

- [] Major depressive disorder [] Post-herpetic neuralgia [] Generalized Anxiety Disorder (GAD)
[] Diabetic peripheral neuropathy (please specify diabetic medications in the medication history)
[] Non-diabetic neuropathy [] Fibromyalgia [] Add-on therapy for partial onset epileptic seizures in adults
Other (specify all): _____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

[] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug Name, Date, Duration. Includes blank lines for entry.

3. PATIENT HISTORY:

Which of the following medications has the patient tried and failed? (check all that apply)

- [] Prozac® (fluoxetine) [] Paxil® (paroxetine) [] Zoloft® (sertraline) [] Celexa® (citalopram) [] Luvox® (fluvoxamine)
[] Wellbutrin® (bupropion) [] Wellbutrin SR® (bupropion SR) [] Wellbutrin XL® (bupropion XL) [] Tramadol
[] Effexor® (venlafaxine) [] Effexor XR® [] Lexapro® [] Neurontin® (gabapentin) [] Carbamazepine
[] Cymbalta®

- a. Has the patient tried any tricyclic antidepressants such as (amitriptyline, etc...)? [] Yes [] No [] N/A
b. Has the patient tried any opioid containing products? [] Yes [] No [] N/A
c. Has the patient tried Lidoderm® or other topical lidocaine? [] Yes [] No [] N/A
d. Has the patient been stabilized in an institutional setting? [] Yes [] No [] N/A
e. Is the patient currently stabilized for over 4 weeks? (Provide dates in the Medication History Section) [] Yes [] No [] N/A
f. Is this a request for continuous therapy? [] Yes [] No [] N/A

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL