



**Independence
Blue Cross**

Prior Authorization Form

Lyrica® / Cymbalta® / Pristiq® / Savella® / Aplenin®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)* Lyrica® Cymbalta® Pristiq® Savella® Aplenin®

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."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

If a patient has contraindication to any of the drugs listed in any of the 3 questions below, please note in the comment section

- 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:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only	Coverage effective date / /
Document # _____	Processor Initials _____ Date _____
M F Rx coverage Y N	STANDARD - SELECT LOB _____
Previous Auth Y N	Approved Reviewer Initials _____ Date _____