04/18/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Lyrica (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Lyrica (IL88).

Drug Name (select from list of drugs shown)

Lyrica (pregabalin) pregabalin

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: ____________________

Patient ID: ____________________

Patient Group No.: ____________________

Patient DOB: ____________________

Patient Phone:

Prescribing Physician

Physician Name: ____________________

Physician Phone: ____________________

Physician Fax: ____________________

Physician Address: ____________________

City, State, Zip: ____________________

Diagnosis: ____________________ **ICD Code:** ____________________

Comments:

Please circle the appropriate answer for each question.		
1. Does the patient have a fibromyalgia, post herpetic neuralgia, or partial onset seizures?	Y N	
[If yes, then no further questions.]		
2. Does the patient have neuropathic pain associated with diabetic peripheral neuropathy?	Y N	
[If no, then skip to question 4.]		
3. Has the patient had a trial and failure of 2 formulary medications (e.g., topical capsaicin, tricyclic antidepressants, tramadol)? Please list medication tried and reason for treatment failure.	Y N	
[No further questions required.]		
4. Does the patient have neuropathic pain associated with spinal cord injury?	Y N	
5. Has the patient had a trial and failure of 2 formulary medications (e.g., topical capsaicin, tricyclic antidepressants, tramadol, or gabapentin)? Please list medication tried and reason for treatment failure.	Y N	

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date