



**Independence  
Blue Cross**

**Prior Authorization Form**

**Lyrica® / Pristiq® / Savella® / Aplenizin® / Gralise®**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)*     Lyrica®     Pristiq®     Savella®     Aplenizin®     Gralise®

Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Office Fax #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

ONLY COMPLETED REQUESTS WILL BE REVIEWED

**\*\*\*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
- 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@catalystrx.com](mailto:FSS_Standard_Medicare@catalystrx.com)**

**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**