Iowa Department of Human Services

Request for Prior Authorization
CHRONIC PAIN SYNDROMES

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for pregabalin (Lyrica®) and milnacipran (Savella™). These drugs will be considered for their FDA indication(s) and other conditions as listed in the compendia. Requests for doses above the manufacturer recommended dose will not be considered. The trial examples below are not an all inclusive list. Please refer to the Preferred Drug List (PDL) located at www.iowamedicaidpdl.com for a complete list of preferred drugs in these therapeutic classes. For patients with a chronic pain diagnosis who are currently taking opioids, as seen in pharmacy claims, a plan to decrease and/or discontinue the opioid(s) must be provided with the initial request. Initial authorization will be given for three (3) months. Requests for renewal must include an updated opioid treatment plan and documentation of improvement in symptoms and quality of life. Requests for non-preferred brand drugs, when there is a preferred A-rated bioequivalent generic product available, are also subject to the Selected Brand Name prior authorization criteria and must be included with this request. Payment will be considered under the following conditions:

Preferred (no PA required within quantity limit)
☐ Duloxetine

Non-Preferred
☐ Cymbalta ☐ Lyrica ☐ Savella

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

☐ **Fibromyalgia (*Lyrica® or Savella™*):** A diagnosis of fibromyalgia with the following documented trials:

a) A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following preferred generic agents: tricyclic antidepressant (amitriptyline, nortriptyline) or SNRI (duloxetine, venlafaxine er).

Gabapentin Trial Dose: _____Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Preferred Drug Trial #2 Name/Dose: _____Trial start date: _____ Trial end date: _____

Reason for Failure: _____

b) Documented non-pharmacologic therapies (such as cognitive behavior therapies, exercise, etc,)

Non-Pharmacological Treatments Tried: _____

Request for Prior Authorization-*Continued*
CHRONIC PAIN SYNDROMES

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Post-Herpetic Neuralgia (*Lyrica*®):** A diagnosis of post-herpetic neuralgia with the following documented trials:

A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant (amitriptyline, nortriptyline), topical lidocaine, or valproate. .

Gabapentin Trial Dose: _____Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Preferred Drug Trial#2 Name/Dose: _____Trial start date: _____ Trial end date: _____

Reason for Failure: _____

☐ **Diabetic Peripheral Neuropathy (*duloxetine or Lyrica*®):** A diagnosis of diabetic peripheral neuropathy with the following documented trials:

A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant (amitriptyline, nortriptyline) or duloxetine.

Gabapentin Trial Dose: _____Trial start date: _____Trial end date: _____

Reason for Failure: _____

Preferred Drug Trial #2 Name/Dose: _____Trial start date: _____ Trial end date: _____

Reason for Failure: _____

☐ **Partial Onset Seizures, as adjunct therapy (*Lyrica*®)**

☐ **Neuropathic Pain associated with spinal cord injury (*Lyrica*®)**

☐ **Other Diagnosis of Use:**_____

Must complete for chronic pain diagnosis:

Initial Requests:

Does the member have current opioid use? ☐ Yes Name/Dose:_____ ☐ No

If yes, provide specific plan, including time line, to decrease and/or discontinue opioid use: _____

_____

Renewal Requests:

Does the member have current opioid use? ☐ Yes Name/Dose:_____ ☐ No

If yes, provide updated opioid treatment plan: _____

_____

Document improvement in symptoms and quality of life: _____

_____

Other relevant information: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*