OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Lyrica® & Lyrica® CR Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

For states, such as GA and AR, that have a terminal illness mandate, and for patients who have a terminal illness, please answer the following:
Will the requested medication be used for the treatment of a terminal condition or associated symptoms? ❑ **Yes** ❑ **No**
If "YES", please indicate the patient's estimated life expectancy:
❑ Less than 6 months ❑ Less than 24 months ❑ Less than ____ months (please specify)

Select the diagnosis below:
❑ Fibromyalgia [**Lyrica immediate-release (IR)** only]
❑ Neuropathic pain associated with diabetic peripheral neuropathy
❑ Neuropathic pain associated with spinal cord injury [**Lyrica immediate-release (IR)** only]
❑ Partial onset seizure, adjunct therapy [**Lyrica immediate-release (IR)** only]
❑ Postherpetic neuralgia (PHN)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:
For Lyrica solution requests, answer the following:
Is the patient unable to swallow tablets or capsules? ❑ **Yes** ❑ **No**

Select the medications the patient has had a trial and failure, contraindication, or intolerance to (Please specify date, duration of trial, and reason for failure):
❑ Amitriptyline Date of trial: _____ Duration of trial: _____ Reason for failure: _____
❑ Cyclobenzaprine Date of trial: _____ Duration of trial: _____ Reason for failure: _____
❑ Duloxetine Date of trial: _____ Duration of trial: _____ Reason for failure: _____
❑ Gabapentin Date of trial: _____ Duration of trial: _____ Reason for failure: _____
❑ Lyrica IR capsules Date of trial: _____ Duration of trial: _____ Reason for failure: _____
❑ Lyrica IR solution Date of trial: _____ Duration of trial: _____ Reason for failure: _____
❑ Other tricyclic antidepressant (Please specify drug, date, duration of trial, AND reason for failure):
Medication name: _____
Date of trial: _____ Duration of trial: _____ Reason for failure: _____

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Lyrica® & Lyrica® CR Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.