Prescriber Criteria Form Lyrica 2024 PA Fax 2898-A v2 010124.docx Lyrica (pregabalin) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Lyrica (pregabalin).

Drug Name: Lyrica (pregabalin)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed as adjunctive therapy for treatment of partial onset seizures (focal-onset seizures)? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for the management of fibromyalgia or the management of neuropathic pain associated with spinal cord injury? [If yes, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for any of the following: A) Management of postherpetic neuralgia, B) Management of neuropathic pain associated with diabetic peripheral neuropathy, C) Cancer-related neuropathic pain, D) Cancer treatment-related neuropathic pain? [If no, then no further questions.]	Yes	No
4	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to gabapentin?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____