

**Neighborhood Health Plan of Rhode Island  
Medical Necessity Request Form  
Lyrica® (Pregabalin)**

Date of Request: \_\_\_\_\_

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Lyrica® (Pregabalin). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

<b>Member Name: (required)</b>	<b>Member ID Number: (required)</b> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table>										
<b>Member Date of Birth: (required)</b> / /	<b>Member Sex:</b> M    F    (Circle One)										
<b>Prescriber Name: (required)</b>	<b>Contact Person at Office:</b>										
<b>Office Phone number: (required)</b> (    ) -	<b>Office Fax Number: (required)</b> (    ) -										

**ASSESSMENT OF BENEFIT NEED:**

- Please describe which indication pregabalin will be treating:
  - Neuropathic pain associated with **diabetic** peripheral neuropathy
  - Postherpetic neuralgia
  - As adjunctive therapy for **adult** patients with partial onset seizures
  - Other (please specify): \_\_\_\_\_
- If pregabalin is being requested for the treatment of neuropathic pain or postherpetic neuralgia, please indicate which medications the patient has failed *in the past 6 months*:

<input type="checkbox"/> Tricyclic antidepressants (i.e. amitriptyline, nortriptyline, desipramine, protriptyline)	<input type="checkbox"/> SSRIs (fluoxetine, citalopram, paroxetine, sertraline)	<input type="checkbox"/> Gabapentin
<input type="checkbox"/> Carbamazepine	<input type="checkbox"/> Lamotrigine	<input type="checkbox"/> Oxcarbazepine
<input type="checkbox"/> Topiramate	<input type="checkbox"/> Valproic Acid	<input type="checkbox"/> Zonisamide
<input type="checkbox"/> Cymbalta		

- If pregabalin is being requested for adjunctive seizure treatment please indicate *current* anticonvulsant therapy:

<input type="checkbox"/> Carbamazepine	<input type="checkbox"/> Phenytoin	<input type="checkbox"/> Lamotrigine
<input type="checkbox"/> Oxcarbazepine	<input type="checkbox"/> Valproic Acid	<input type="checkbox"/> Gabapentin
<input type="checkbox"/> Topiramate	<input type="checkbox"/> Tiagabine	<input type="checkbox"/> Zonisamide
<input type="checkbox"/> Levetiracetam		

- For all other uses of pregabalin please describe which medications the patient has failed *in the past 6 months*:  
\_\_\_\_\_

5. Please indicate your desired outcome with this therapy:  
\_\_\_\_\_

6. If this is a renewal; has the desired outcome been achieved?    YES     NO

- Please indicate the dosing schedule and the dose you desire for your patient

DOSE	<input type="checkbox"/> 25mg	<input type="checkbox"/> 50mg	<input type="checkbox"/> 75mg	<input type="checkbox"/> 100mg	<input type="checkbox"/> 150mg	<input type="checkbox"/> 200mg	<input type="checkbox"/> 225mg	<input type="checkbox"/> 300mg
SCHEDULE	<input type="checkbox"/> Twice daily (preferred)		<input type="checkbox"/> Three times daily					

**BENEFIT TERMS UPON APPROVAL:**

If approved, pregabalin will be authorized for one year with yearly renewal if therapy is successful in meeting physician defined outcomes.

**All information provided on this form is accurate as of this date.**

**Provider Signature:** \_\_\_\_\_ **NPI:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Completed forms should be faxed to:  
Customer Service Department  
NHPRI  
866-423-0945**