

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 informa	ation above. It must be legible, correct, and complete or f	orm 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 <u>www.iowamedicaidpdl.com</u> 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:

Pre	<u>eferred (no PA required within quantity limit)</u> Duloxetine		Non-Preferred		Lyrica		Savella
	Strength	Dosage Instructions	-	-	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: 						
		amitriptyline, nortriptyline) or S					
	Reason for Failure:						
	Preferred Drug Trial #2	Name/Dose:	Trial	start dat	e: Tria	l end d	ate:
	Reason for Failure:						
	b) Documented non-phar	macologic therapies (such as	cognitive behavior tl	herapies	, exercise, etc,	.)	

Non-Pharmacological Treatments Tried:

Iowa Department of Human Services

Request for Prior Authorization-Continued CHRONIC PAIN SYNDROMES

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	Post-Herpetic Neuralgia (Lyrica®): A diagnos	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 antic (amitriptyline, nortriptyline), topical lidocaine, or valproate							
	Gabapentin Trial Dose:	Trial start date:	tart date: Trial end date:		_			
	Reason for Failure:							
	Preferred Drug Trial#2 Name/Dose:	Trial s	tart date:	Trial end dat	date:			
	Reason for Failure:							
	Diabetic Peripheral Neuropathy (<i>duloxetine or Lyrica[®]):</i> 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	d date:	-			
	Reason for Failure:							
	Preferred Drug Trial #2 Name/Dose:	ed Drug Trial #2 Name/Dose: Trial start date: Trial		Trial end d	end date:			
	Reason for Failure:							
	Neuropathic Pain associated with spinal co Other Diagnosis of Use:				_			
	st complete for chronic pain diagnosis:							
	al Requests:	V N (5			— N			
	es the member have current opioid use?							
If ye	es, provide specific plan, including time line, to c	decrease and/or discontinu	e opioid use: _					
Rer	newal Requests:							
Doe	es the member have current opioid use? $\ \square$	Yes Name/Dose:			🗌 No			
lf ye	es, provide updated opioid treatment plan:							
Doc	cument improvement in symptoms and quali	ty of life:			_			
Oth	er relevant information:							
	ach lab results and other documentation as l		1					
Pres	scriber signature (Must match prescriber listed abo	ove.)	Date of subm	nission				
	ORTANT NOTE: In evaluating requests for prior aut lical necessity only. If approval of this request is grai							

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.