PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Gralise® (gabapentin)

Member

Last Name: ____________________ First Name: ____________________

ID #: ____________________ DOB: ____________ Gender: ____________

Primary Care Physician: ____________________

Requesting Provider: ____________________ Prov. Phone: ____________ Prov. Fax: ____________

Provider Address: ____________________

Provider NPI: ____________________ Contact Name: ____________________

Provider Signature: ____________________ Date: ____________

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Gralise 300mg tablet ☐ Gralise 600mg tablet

Start date (or date of next dose): ____________________

Date of last dose (if applicable): ____________________

Dosing frequency: ____________________

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of postherpetic neuralgia
   - Please fax supporting documentation of diagnosis along with request for coverage
2. Trial and failure with or intolerance to all of the following:
   - one generic tricyclic antidepressant (e.g. amitriptyline) at maximally tolerated doses used for a minimum of 28 days
   - 1,800mg daily of gabapentin (immediate release) used for a minimum of 28 days
3. Minimum age of 18 years

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

Priority Health Precertification Documentation

A. The condition the drug is being requested for:

☐ Postherpetic neuralgia (documentation provided to support diagnosis)

☐ *Other – the patient's condition is:* ____________________

Rationale for use: ____________________

All fields must be complete and legible for review. Your office will receive a response via fax.

New 07/2017
Last reviewed 07/2018

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B. The patient has tried the following medications:

Drug	Dose	Dates of Use	Therapy Outcome
____________	____________	____________	______________________________
____________	____________	____________	______________________________
____________	____________	____________	______________________________
____________	____________	____________	______________________________

☐ Not all requirements are met – Below is rationale for use:

____

C. The patient is at least 18 years of age:

☐ Yes
☐ No

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New 07/2017
Last reviewed 07/2018