catamaran™

Catamaran Prior Authorization Department
Phone: 866-235-3062
Fax: 866-391-7222

Prescriber Information

Last Name:	**First Name**
DEA/NPI:	**Specialty:**
Phone - -	**Fax** - -

Member Information

Last Name:	**First Name**
Member ID Number	**DOB:** - -

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

Lyrica (pregabalin) Prior Authorization Criteria

You must answer ALL of the following questions		
1. What is the patient's diagnosis? Please document diagnosis and ICD-9 code:		
2. Has the patient demonstrated an inadequate treatment response or is intolerant to or had a confirmed adverse event with any of the following medications within the past 180 days? **(Please circle)** • Cymbalta • Carbamazepine • Tricyclic antidepressants • FLUPHENAZINE • Gabapentin • Trazodone • Other drug FDA approved or medically accepted for neuropathic pain associated with DPN: Please document: _____	Y	N
3. Has the patient demonstrated an inadequate treatment response or is intolerant to or had a confirmed adverse event with any of the following medications within the past 180 days? **(Please circle)** • Carbamazepine • Gabapentin • Lidocaine patch (Lidoderm) • Tricyclic antidepressants • Other drug FDA approved or medically accepted for herpetic neuralgia: Please document: _____	Y	N

4. Does the patient have widespread pain (on the left and right side of the body and above and below the waist) present for at least 3 months?	Y	N
5. Does the patient have axial skeletal pain (cervical spine or anterior chest or thoracic spine or low back) present for at least 3 months?	Y	N
6. Does the patient have at least 11 of 18 positive (painful) specific bilateral tender point sites after digital palpitation with an approximate force of 4kg? Please document:_____ • Occiput • Low cervical • Trapezius • Supraspinatus • Second rib • Lateral epicondyle • Gluteal • Greater trochanter • Knee	Y	N
7. Has the patient demonstrated an inadequate treatment response or is intolerant to or had a confirmed adverse event with any of the following medications? Please select and document intolerance/adverse event:_____ • Cyclobenzaprine • Tricyclic antidepressants • Fluoxetine • Cymbalta (duloxetine HCl) • Savella (milnacipran)	Y	N

Comments: _____

Information given on this form is accurate as of this date.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 866-235-3062.

I understand that Catamaran's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).