Prescriber Criteria Form
Lyrica 2026 PA Fax 2898-A v2 010126.docx
Lyrica (pregabalin)
Prior authorization only applies to patients 65 years of age or older.
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 skip to question 3.]	Yes	No
2	Is the requested drug being prescribed for any of the following: A) Management of fibromyalgia, B) Management of neuropathic pain associated with spinal cord injury, C) Cancer-related neuropathic pain, D) Cancer treatment-related neuropathic pain? [If no, then skip to question 5.]	Yes	No
3	Is the request for Lyrica (pregabalin) oral solution? [If no, then no further questions.]	Yes	No
4	Does the patient have difficulty swallowing solid oral dosage forms (e.g., tablets, capsules)? [No further questions.]	Yes	No
5	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? [If no, then no further questions.]	Yes	No
6	Is the request for Lyrica (pregabalin) oral solution? [If no, then skip to question 8.]	Yes	No

7	Does the patient have difficulty swallowing solid oral dosage forms (e.g., tablets, capsules)? [If no, then no further questions.]	Yes	No
8	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to generic 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:**_____