

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.  
Allow at least 24 hours for review.**

**Section A – Member Information**

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

**Section B - Provider Information**

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax attention to:			

**Section C - Medical Information**

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

**Section D – Previous Medication Trials**

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:  
Please refer to the patient's PDL at [www.uhcprovider.com](http://www.uhcprovider.com) for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have any of the following diagnoses?</b> <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Neuropathic Pain Associated with Spinal Cord Injury <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Diabetic Peripheral Neuropathy (DPN) <input type="checkbox"/> Post Herpetic Neuralgia (PHN)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have history of failure, contraindication, or intolerance to treatment with any of the following?</b> <i>(If yes, check which applies and complete section D above)</i> <input type="checkbox"/> Tricyclic Antidepressant at the maximum tolerated dose for 6 – 8 weeks (amitriptyline, nortriptyline, desipramine, imipramine) <input type="checkbox"/> Selective Serotonin Reuptake Inhibitor (SSRI) at the maximum tolerated dose for 6 – 8 weeks (fluoxetine, paroxetine, sertraline, citalopram, escitalopram, fluvoxamine) <input type="checkbox"/> Serotonin and Norepinephrine Reuptake Inhibitor (SNRI) anti-depressant at the maximum tolerated dose for 6 – 8 weeks (duloxetine, venlafaxine)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have history of failure, contraindication or intolerance to gabapentin (generic Neurontin) at a minimum dose of 1800 mg daily for <u>4 weeks</u>?</b> <i>(If yes, complete section D above)</i>
<b>LYRICA CR – DPN AND PHN</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have history of failure, contraindication, or intolerance to Lyrice immediate release capsules or suspension?</b> <i>(If yes, complete section D above)</i>

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

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