

Iowa Department of Human Services  
REQUEST FOR PRIOR AUTHORIZATION  
CHRONIC PAIN SYNDROMES

Duloxetine (Cymbalta®), Milnacipran (Savella™), Pregabalin (Lyrica®)  
*This form is used for both preferred and non-preferred agents.*  
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid	Member ID #: <input type="text"/>	Patient Name: <input type="text"/>	DOB: <input type="text"/>
Patient Address: <input type="text"/>			
Provider NPI: <input type="text"/>	Prescriber Name: <input type="text"/>	Phone: <input type="text"/>	
Prescriber Address: <input type="text"/>			Fax: <input type="text"/>
Pharmacy Name: <input type="text"/>	Address: <input type="text"/>	Phone: <input type="text"/>	
<b>Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.</b>			
Pharmacy			
NPI: <input type="text"/>	Pharmacy Fax: <input type="text"/>	NDC : <input type="text"/>	

**Prior authorization is required for duloxetine (Cymbalta®), pregabalin (Lyrica®), and milnacipran (Savella™). These drugs will be considered for their FDA indication(s) and other conditions as listed in the compendia. A trial and therapy failure with Savella™ is required prior to consideration of Cymbalta® or Lyrica® for a fibromyalgia diagnosis, when the criteria for coverage are met. Requests for concomitant use of these agents for an indicated chronic pain diagnosis will not be approved. The trial examples below are not an all inclusive list. Please refer to the Preferred Drug List (PDL) located at [www.iowamedicaidpdl.com](http://www.iowamedicaidpdl.com) for a complete list of preferred drugs in these therapeutic classes. Payment will be considered under the following conditions:**

Cymbalta® <input type="checkbox"/>	Lyrica® <input type="checkbox"/>	Savella™ <input type="checkbox"/>
Strength	Dosage Instructions	Quantity
_____	_____	_____
	Days Supply	
	_____	

**Fibromyalgia (Cymbalta®, Lyrica®, or Savella™):** A diagnosis of fibromyalgia with the following documented trials:

a) A trial and therapy failure at a therapeutic dose with **three** drugs from three distinct therapeutic classes from the following: tricyclic antidepressant (amitriptyline, nortriptyline), muscle relaxant (baclofen, cyclobenzaprine, tizanidine), SSRI/SNRI (fluoxetine, venlafaxine er), tramadol, or gabapentin.

**Preferred Drug Trial #1** Name/Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**Preferred Drug Trial #2** Name/Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**Preferred Drug Trial #3** Name/Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

b) Documented non-pharmacologic therapies (such as cognitive behavior therapies, exercise, etc.)

Non-Pharmacological Treatments Tried: \_\_\_\_\_

c) Documented trial and therapy failure with Savella™, prior to consideration of Cymbalta® or Lyrica®.

**Savella™ Trial:** Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**REQUEST FOR PRIOR AUTHORIZATION-Continued**  
**Duloxetine (Cymbalta®), Milnacipran (Savella™), Pregabalin (Lyrica®)**

**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 at least **two** drugs from two distinct therapeutic classes from the following: tricyclic antidepressant (amitriptyline, nortriptyline), topical lidocaine, valproate, carbamazepine, or gabapentin.

**Preferred Drug Trial #1** Name/Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**Preferred Drug Trial #2** Name/Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**Diabetic Peripheral Neuropathy (Cymbalta® or Lyrica®):** A diagnosis of diabetic peripheral neuropathy with the following documented trials:

A trial and therapy failure at a therapeutic dose with at least **two** drugs from two distinct therapeutic classes from the following: tricyclic antidepressant (amitriptyline, nortriptyline), topical lidocaine, tramadol, or gabapentin.

**Preferred Drug Trial #1** Name/Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**Preferred Drug Trial #2** Name/Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**Partial Onset Seizures, as adjunct therapy (Lyrica®):**

**Major Depressive Disorder or Generalized Anxiety Disorder (Cymbalta®):**

**Other Diagnosis of Use:** \_\_\_\_\_

Other relevant information: \_\_\_\_\_

*Attach lab results and other documentation as necessary.*

Prescriber Signature: \_\_\_\_\_ Date of Submission: \_\_\_\_\_

**\*MUST MATCH PRESCRIBER LISTED ABOVE**

**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for 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.