MERCYCARE HEALTH PLANS

PRIOR AUTHORIZATION FAX REQUEST FORM - **FAX to 608-758-7726**

FOR **Fibromyalgia Agents**

Name	DOB
MercyCare ID#	

FOR MERCYCARE USE ONLY

Primary Plan: *Tier 2 3*

Secondary Plan:

Transaction #

NOTICE: This form is to be used for:
Prior Approval of Savella or Lyrica

Drug Name:	Strength:	Dosing:	Quantity:
For diagnoses other than fibromyalgia, please use the Lyrica PA form.	Duration of Therapy:		

Please check the appropriate box(es) and send supporting documentation. **Usage compatible with the FDA approval for the treatment of fibromyalgia.**

❑ New therapy ❑ Continuation of previously approved MercyCare override ❑ Continuation of therapy authorized by previous insurance

Drug Requested

❑ **Savella** (maximum dose 100 mg BID) ❑ **Lyrica** (maximum dose 225 mg BID)

Fibromyalgia Diagnosis

❑ Diagnosis of FM using ACR criteria: widespread pain/symptoms for at least 3 months using the Widespread Pain Index (WPI) and Symptom Severity (SS) scale (please list scores for both)

❑ WPI: __________ ❑ SS: __________

Failure of 12-Week Trials of First-Line Agents

❑ Amitriptyline Dates used: _______________ ❑ SSRI +/- NSAID : _______________ Dates used: __________

❑ Cyclobenzaprine Dates used: _______________ ❑ Tramadol +/- acetaminophen Dates used: _______________

❑ Gabapentin max dose: _______ Dates used: ____________ ❑ Other: ___________________ Dates used: _______________

Non-Pharmacologic Therapies

❑ Documented exercise plan

❑ Cognitive behavioral therapy Dates tried: _______________ Outcome: ___________________________________

❑ Complementary therapies: ____ Dates tried: _______________

Outcome: ___________________________________

Prescriber Signature:	Date	Phone #	Fax #
Prescriber Name (Please Print)	Specialty	Location	

Approved thru: / /

3—6—9—12 months

Denied

D2—D6

Redirect

File

Pharmacist Signature:_______________________________ / /