



Office use only:	Reviewed by: _____
Review date: _____	Approved Denied

Prior Authorization Form

LYRICA® (pegabalin)

ONLY COMPLETED FORMS WILL BE RECEIVED

Dosage: _____

Date: _____

Patient Name: _____

DOB: _____

Insurance ID #: _____

Office Contact: _____

Prescribing Physician: _____

Office Phone: _____

Provider Specialty: _____

Office Fax: _____

1. Diagnosis for drug requested:

- Diabetic peripheral neuropathy
- Post-herpetic neuralgia
- Add-on therapy for partial onset epileptic seizures in adults
- Other (be specific): _____

2. Patient History:

Does the patient have a diagnosis of diabetic peripheral neuropathy? Yes No
 Has the patient tried and failed gabapentin (Neurontin®)? Yes No

Please attach any supporting clinical information that may be useful in the review of this prior authorization.

Fax completed form to (706) 549-8004. Your office will receive a response via fax.