Neurontin (gabapentin)
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

1. Patient information	**2. Physician information**
Patient name: ______________________	Prescribing physician: ______________________
Patient ID #: ______________________	Physician address: ______________________
Patient DOB: ______________________	Physician phone #: ______________________
Date of Rx: ______________________	Physician fax #: ______________________
Patient phone #: ______________________	Physician specialty: ______________________
Patient email address: ______________________	Physician DEA: ______________________
	Physician NPI #: ______________________
	Physician email address: ______________________

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
			Specify:

7. Diagnosis

8. Approval criteria: Item (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

- ☐ Yes ☐ No Is the request for a dose less than or equal to 1,400 mg per day?
- ☐ Yes ☐ No Does the patient have a diagnosis of chronic kidney disease in the last 365 days?
- ☐ Yes ☐ No Does the patient have a dialysis CPT code in the last 180 days?
- ☐ Yes ☐ No Does the patient have a diagnosis of epilepsy/convulsions, neuropathic pain, migraine, restless leg syndrome or fibromyalgia in the last 730 days?
- ☐ Yes ☐ No Does the patient have a history of an inferred migraine agent in the last 90 days?
- ☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days.

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☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents in this class?

☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

☐ Yes ☐ No Is there additional medical information that justifies the use of the medication? If Yes, please indicate the additional medical information that justifies the use of the medication:

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For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **http://www.txvendordrug.com/formulary/formulary-search.asp**.

9. Physician signature

______________________________ Prescriber or authorized signature	______________________________ Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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