US Family Health Plan
Prior Authorization Request Form for
gabapentin ER 24 hr tablets (**Gralise**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. What is the patient's diagnosis or indication?	☐ Post herpetic neuralgia – Proceed to question **3** ☐ Other – **STOP** Coverage not approved	
3. Has the patient tried and failed gabapentin or pregabalin at maximally tolerated dose?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Does the patient have a contraindication to, intolerability to or has tried and failed a tricyclic antidepressant (TCA) (for example: amitriptyline, amoxapine, desipramine) at maximally tolerated dose?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[28 December 2022]