

US Family Health Plan Prior Authorization Request Form for gabapentin enacarbil (**Horizant**)

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?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Has the patient tried and failed gabapentin or pregabalin at maximally tolerated dose?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. What is the patient's diagnosis or indication?	<input type="checkbox"/> Post herpetic neuralgia – Proceed to question 4 <input type="checkbox"/> Restless leg syndrome – Proceed to question 5 <input type="checkbox"/> Other – 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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
5. Does the patient have a contraindication to, intolerability to or has tried and failed pramipexole or rotigotine at maximally tolerated dose?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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
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