



**BlueCross  
BlueShield  
of Arizona**

An Independent Licensee  
of the Blue Cross and  
Blue Shield Association

**Precertification Request Form for  
Lyrica®**

**Precertification for Lyrica® requires completion of this form in its entirety.** All requested data must be provided. Once completed the form must be signed by the medical provider and faxed back to BCBSAZ Pharmacy Management at **(602) 864-3126**. Incomplete forms may result in denial of requested medication due to lack of needed information. **Lyrica (pregabalin) is chemically similar to gabapentin (Neurontin®) and Neurontin® is commercially available as a generic medication.**

Provider Information			Patient Information		
Physician's Name			Patient's Name		
Physician Specialty		NPI #	BCBSAZ Member ID		
Mailing Address			Date of Birth / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
City	State	Zip Code	Patient's Address		
Phone # ( ) - ext	Fax # ( ) -		City	State	Zip Code

**Medication Information**

Medication Name & Strength:	_____
Directions for Use & Duration:	_____
Diagnosis Code:	_____
Diagnosis:	_____

**All of the following questions and/or information must be answered and provided to assess request:  
(Office notes are not needed if all information has been provided unless otherwise stated)**

Request is for which of the following condition(s):	
<input type="checkbox"/>	Adjunctive therapy for partial onset seizures
<input type="checkbox"/>	Neuropathic pain associated with diabetic peripheral neuropathy
<input type="checkbox"/>	Post-herpetic neuralgia
<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<u>Other neuropathic pain condition not listed above and as defined by the US National Guideline Clearinghouse as pain initiated or caused by a primary lesion or dysfunction in the nervous system and is characterized by spontaneous pain described as lancinating, paroxysmal, burning, constant, cramping; and evoked pain of dysethesia, allodynia, hyperalgia, or hyperpathia (last 2 most recent physician office notes are required)</u>  Describe condition: _____
<input type="checkbox"/>	<u>Other neuropathic pain not listed above, provider has started other therapy to treat the condition causing the neuropathic pain, when applicable (last 2 most recent physician office notes are required)</u>  Describe condition: _____
<input type="checkbox"/>	<u>Other condition (last 2 most recent physician office notes are required)</u>  Describe condition: _____

**Signature affirms that information given on this form is true and accurate and reflects office notes**

Physician's Signature	Date
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