



# New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Cymbalta® (Duloxetine)

DATE OF MEDICATION REQUEST:      /      /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

Patient's Name

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Medicaid Number

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Date of Birth (MM/DD/YYYY)

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Gender

Male

Female

Drug Name

Strength

Dosing Directions

Length of Therapy

## SECTION II: CLINICAL HISTORY

- Does the patient have a diagnosis of major depressive disorder?  Yes  No  
If yes to Question 1, please proceed to *Section III: Non-Preferred Drug Approval Criteria*
- Does the patient have a diagnosis of generalized anxiety disorder?  Yes  No
- Does the patient have a diagnosis of diabetic peripheral neuropathy?  Yes  No  
If yes to Question 3, has the patient experienced a treatment failure, or is not a candidate for treatment with at least two of the following agents: any tricyclic antidepressant, gabapentin, topical lidocaine or tramadol?  Yes  No
- Does the patient have a diagnosis of fibromyalgia? (If yes, continue to questions #5 to #11)  Yes  No
- Has widespread pain been present for at least 3 months?  Yes  No
- Is pain present in at least 11 out of the 18 specific tender points (according to ACR guidelines)?  Yes  No
- On a separate sheet, please describe any physical fitness interventions that have been done.
- On a separate sheet, please describe any behavioral health interventions.
- Has the patient experienced a treatment failure, or is not a candidate for treatment with at least two of the following agents: amitriptyline, cyclobenzaprine or fluoxetine?  Yes  No  
Please list treatment failure, maximum doses failed and dates:  
\_\_\_\_\_
- Does the patient have a diagnosis of chronic musculoskeletal pain?  Yes  No  
Please describe:  
\_\_\_\_\_
- If yes to Question 10, has the patient experienced a treatment failure, or is not a candidate for treatment with acetaminophen, an NSAID and cyclooxygenase 2 inhibitors?  Yes  No
- Is the patient currently on pregabalin or milnacipran?  Yes  No  
If yes, please note that concurrent therapy will only be approved for 30 days.
- Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

If you are requesting Cymbalta® for a diagnosis of major depressive disorder proceed to Section III. If not, then proceed to Section IV.

