



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

Fibromyalgia

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

- Does the patient have a diagnosis of fibromyalgia? 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
- Please describe any physical fitness interventions that have been done. If additional space is needed, please use another page.
- Has the patient experienced a treatment failure, or is not a candidate for, treatment with at least ONE of the following agents: amitriptyline or cyclobenzaprine? Please list treatment failure, maximum doses failed and dates: Yes No
- Is the patient currently on pregabalin (Lyrica®), duloxetine (Cymbalta®), or milnacipran (Savella®)? 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.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ DATE: _____