

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

EXTENDED RELEASE GABAPENTIN (Gralise® and Horizant®)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED
FORM TO 855-828-4992**

GRALISE® CRITERIA:

- Minimum age requirement: 18 years old.
- Documented diagnosis of postherpetic neuralgia.
- Dose limited to less than or equal to 1800mg daily.
- Documented failure of a trial of regular release gabapentin, at therapeutic dose, for one month.

HORIZANT® CRITERIA:

- Minimum age requirement: 18 years old.
- Documented diagnosis of restless leg syndrome.
- Dose limited to less than or equal to 600mg daily.
- Documented failure of a trial of regular release gabapentin, at therapeutic dose, for one month

AUTHORIZATION:

Initial authorization will be granted for one year.

RE-AUTHORIZATION:

Updated letter of medical necessity

07/11/2011

<https://medicaid.utah.gov/pharmacy/>