



Please complete ALL information below and fax your request to 1-888-671-5285

### Horizant® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Moderate-to-severe primary restless legs syndrome (RLS)	
<input type="checkbox"/> Postherpetic neuralgia (PHN)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<b>Moderate-to-severe primary restless legs syndrome (RLS):</b>	
Does the patient have a trial and failure, contraindication, or intolerance to ropinirole <u>or</u> pramipexole? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If this is a reauthorization request, answer the following:</b>	
Has the patient experienced an improvement in RLS disease symptoms (e.g., decrease in symptom onset or severity, improved sleep, or decrease in symptom intensity)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Postherpetic Neuralgia (PHN):</b>	
Has the patient tried and had an inadequate response to a dose of at least 1800 mg of generic gabapentin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have a history of intolerance to generic gabapentin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If this is a reauthorization request, answer the following:</b>	
Has the patient experienced an improvement in PHN disease symptoms (e.g., decrease in pain severity)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Quantity limit requests:</b>	
What is the quantity requested per DAY? _____	
<b>What is the reason for exceeding the plan limitations?</b>	
<input type="checkbox"/> Titration or loading dose purposes	
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)	
<input type="checkbox"/> Requested strength/dose is not commercially available	
<input type="checkbox"/> Other: _____	

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

\_\_\_\_\_

Please note: This request may be denied unless all required information is received.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.

Office use only: Horizant\_FSP\_2018Mar-W