FUTURE SCRIPTS

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:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderate-to-severe primary restless legs syndrome (RLS)
❑ Postherpetic neuralgia (PHN)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Moderate-to-severe primary restless legs syndrome (RLS):

Does the patient have a trial and failure, contraindication, or intolerance to ropinirole **or** pramipexole? ❑ **Yes** ❑ **No**

If this is a reauthorization request, answer the following:

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)? ❑ **Yes** ❑ **No**

Postherpetic Neuralgia (PHN):

Has the patient tried and had an inadequate response to a dose of at least 1800 mg of generic gabapentin? ❑ **Yes** ❑ **No**

Does the patient have a history of intolerance to generic gabapentin? ❑ **Yes** ❑ **No**

If this is a reauthorization request, answer the following:

Has the patient experienced an improvement in PHN disease symptoms (e.g., decrease in pain severity)? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ 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)
❑ Requested strength/dose is not commercially available
❑ 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.