

**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR  
CYMBALTA FOR FIBROMYALGIA**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Fibromyalgia Completion Instructions, F-00282A. Providers may refer to the Forms page of the ForwardHealth Portal at [www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage](http://www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage) for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Fibromyalgia form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. Providers may call Provider Services at (800) 947-9627 with questions.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name  
Cymbalta

5. Drug Strength

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier (NPI) — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

**SECTION III — CLINICAL INFORMATION**

13. Diagnosis Code and Description

14. Does the member have a diagnosis of fibromyalgia?

Yes

No

**SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF LYRICA**

15. Has the member previously taken Lyrica?

Yes

No

16. Has the member taken Lyrica for fibromyalgia and experienced an unsatisfactory therapeutic response?

Yes

No

If yes, indicate the approximate dates Lyrica was taken in the space provided.

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DT-PA097-097

**SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF LYRICA (Continued)**

17. Has the member experienced a clinically significant adverse drug reaction to Lyrica?  Yes  No

If yes, list the specific details about the clinically significant adverse drug reaction(s) and the approximate dates Lyrica was taken in the space provided.

18. Is there a clinically significant drug interaction between another medication the member is taking and Lyrica?  Yes  No

If yes, list the medication(s) and interaction(s) in the space provided.

19. Does the member have a medical condition(s) or contraindication(s) that prevents him or her from taking Lyrica?  Yes  No

If yes, list the medical condition(s) or contraindication(s) in the space provided.

**SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF SAVELLA**

20. Has the member previously taken Savella?  Yes  No

21. Has the member taken Savella for fibromyalgia and experienced an unsatisfactory therapeutic response?  Yes  No

If yes, indicate the approximate dates Savella was taken in the space provided.

22. Has the member experienced a clinically significant adverse drug reaction to Savella?  Yes  No

If yes, list the specific details about the clinically significant adverse drug reaction(s) and the approximate dates Savella was taken in the space provided.

23. Is there a clinically significant drug interaction between another medication the member is taking and Savella?  Yes  No

If yes, list the medication(s) and interaction(s) in the space provided.

24. Does the member have a medical condition(s) or contraindication(s) that prevents him or her from taking Savella?  Yes  No

If yes, list the medical condition(s) or contraindication(s) in the space provided.

25. **SIGNATURE** — Prescriber

26. Date Signed

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

27. National Drug Code (11 Digits)

28. Days' Supply Requested (Up to 365 Days)

29. NPI

30. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

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**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA (Continued)**

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31. Place of Service

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32. Assigned PA Number

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33. Grant Date

34. Expiration Date

35. Number of Days Approved

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**SECTION V — ADDITIONAL INFORMATION**

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36. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

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