

**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR  
CYMBALTA FOR DIABETIC PERIPHERAL NEUROPATHY (DPN)**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Diabetic Peripheral Neuropathy (DPN) Completion Instructions, F-00285A. 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 Diabetic Peripheral Neuropathy (DPN) 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 DPN?

Yes  No

15. Does the member have Type I diabetes?

Yes  No

16. Does the member have Type II diabetes?

Yes  No

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

17. Has the member previously taken Lyrica?

Yes  No

18. Has the member taken Lyrica for DPN 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-PA092-092

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

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19. 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.

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20. 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.

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21. 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.

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22. **SIGNATURE** — Prescriber

23. Date Signed

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

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24. National Drug Code (11 Digits)

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

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26. NPI

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27. 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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28. Place of Service

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29. Assigned PA Number

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30. Grant Date

31. Expiration Date

32. Number of Days Approved

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**SECTION V — ADDITIONAL INFORMATION**

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33. 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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