PRIOR AUTHORIZATION REQUEST

GRALISE

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for initial therapy or for continuation of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

If you have any questions, call: 1-888-258-8250

Version 05.2026

PRIOR AUTHORIZATION REQUEST

3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
8	What is the patient's condition? [] Postherpetic neuralgia (If checked, go to 9) [] Restless Legs Syndrome (If checked, go to 11) [] Other (If checked, no further questions)		
9	What medication is being requested? [] Gralise (If checked, go to 10) [] Gabapentin ER (Gralise) (If checked, go to 12) [] Horizant (gabapentin enacarbil) (If checked, go to 10)		
10	Has the patient had a trial and failure (at least 3 months) or intolerance to generic Gabapentin ER? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 12.] [If no, no further questions.]	Yes	No
11	What medication is being requested? [] Gabapentin ER (Gralise) (If checked, no further questions) [] Horizant (gabapentin enacarbil) (If checked, go to 13)		

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12	Does dosing exceed Food and Drug Administration (FDA) approved labeling for the requested indication? [Note: Dosing: Gabapentin ER (Gralise) max dose: 1800mg/day. Horizant max dose: 1200mg/day.] [No further questions.]	Yes	No
13	Does the patient have a documented diagnosis of moderately to severely active restless legs syndrome? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Has the patient had a trial and failure for at least 90 days with pramipexole and ropinirole unless contraindicated or intolerant to both products? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Does dosing exceed Food and Drug Administration (FDA) approved labeling for the requested indication? [Note: Dosing: Horizant max dose: 1200mg/day.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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