

2019 lidocaine 5% patch (generic Lidoderm®) or lidocaine 5% ointment Prior Authorization Request

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(You must complete all 3 pages.)

Coverage Criteria for lidocaine 5% PATCH (generic Lidoderm):

- Covered for the diagnosis of pain associated with post-herpetic neuralgia.
- Covered for the diagnosis of diabetic peripheral neuropathy.
- Covered for the diagnosis of cancer neuropathy, including treatment-related neuropathy associated with radiation treatment or chemotherapy.
- Authorization period: Remainder of contract year.

Coverage Criteria for lidocaine 5% OINTMENT:

- Covered for the production of anesthesia of accessible mucous membranes of the oropharynx, for lubrication during intubation, and for the temporary relief of pain associated with minor burns, sunburn, abrasions of the skin, and insect bites
- Covered when used in a compound when used for the production of anesthesia of accessible mucous membranes of the oropharynx, for lubrication during intubation, and for the temporary relief of pain associated with minor burns, sunburn, abrasions of the skin, and insect bites
AND all active ingredients in the compounded product are FDA approved for topical use
- Authorization period: 3 months

Fax completed form to: 1-800-408-2386

For urgent requests, please call: 1-800-414-2386

Patient information		Prescriber information	
Patient name	Today's date	Physician specialty	
Patient insurance ID number	Physician name	NPI/DEA number	
Patient address, city, state, ZIP	Physician address, city, state, ZIP		
Patient home telephone number	M.D. office telephone number		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient date of birth	M.D. office fax number	
Diagnosis and medical information			
Medication requested <input type="checkbox"/> lidocaine 5% PATCH (generic Lidoderm) <input type="checkbox"/> lidocaine 5% OINTMENT		Frequency	
New prescription OR date therapy initiated	Quantity	Day supply	Expected length of therapy
Diagnosis (Please check all boxes that apply and include all office notes supporting diagnosis.)			
For lidocaine 5% PATCH:			
<input type="checkbox"/> Post herpetic neuralgia <input type="checkbox"/> Diabetic peripheral neuropathy <input type="checkbox"/> Cancer neuropathy			
Other diagnoses/ICD 10 codes: _____			
For lidocaine 5% OINTMENT:			
<input type="checkbox"/> Production of anesthesia of accessible mucous membranes of the oropharynx			
<input type="checkbox"/> Use as a lubricant for intubation			
<input type="checkbox"/> Temporary relief of pain associated with minor burns			
<input type="checkbox"/> Temporary relief of pain associated with sunburn			
<input type="checkbox"/> Temporary relief of pain associated with abrasions of the skin			
<input type="checkbox"/> Temporary relief of pain associated with insect bites			
Other diagnoses/ICD 10 codes: _____			
If requesting lidocaine PATCH, please answer questions 1-3 AND 9-10			
If requesting lidocaine OINTMENT, please answer questions 4-8 AND 9-10			

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If requesting lidocaine PATCH, please answer questions 1-3 AND 9-10

Please check all boxes that apply for lidocaine 5% PATCH:

1. Patient is stable on current drug(s) and/or current quantity, and medication change would likely result in high risk of significant adverse clinical outcome.
2. All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.
3. Yes No **Lidocaine 5% PATCH has a quantity limit of 90 PATCHES per 30 days. Does the patient require higher dosage (quantity limit exception)?**
 ▶ If yes, indicate quantity requested: _____ PATCHES per 30 days OR quantity _____ PATCHES per day
 The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.
 The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

If requesting lidocaine OINTMENT, please answer questions 4-8 AND 9-10

Please check ALL boxes that apply for lidocaine 5% OINTMENT:

4. Lidocaine 5% OINTMENT is being purchased AND administered by a physician (or by personnel under direct supervision of a physician) during a physician's professional service (i.e. the drug is being furnished "incident to a physician's service").

5. Lidocaine 5% OINTMENT is being used as part of a **compounded product** with the following ingredients:

INGREDIENT NAME	PRODUCT NDC	QUANTITY

6. Patient is stable on current drug(s) and/or current quantity, and medication change would likely result in high risk of significant adverse clinical outcome.
7. All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.
8. Yes No **Lidocaine 5% OINTMENT has a quantity limit of 35.44 GRAMS per 30 days. Does the patient require higher dosage (quantity limit exception)?**
 ▶ If yes, indicate quantity requested: _____ GRAMS per 30 days OR quantity _____ GRAMS per day
 The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.
 The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

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Please check all boxes that apply (continued):

9. Please list all medications the patient has tried specific to the diagnosis and specify below.

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

10. **Other supporting information**

*NOTE: All exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature	Date
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