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2020 lidocaine 5% patch (generic Lidoderm®), lidocaine 5% ointment, or lidocaine/prilocaine 2.5%/2.5% cream Prior Authorization Request

(You must complete all 4 pages.)

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

- Covered for a diagnosis of pain associated with post-herpetic neuralgia, diabetic neuropathy, or cancer-related neuropathy (including treatment-related neuropathy, such as neuropathy associated with radiation treatment or chemotherapy)

Authorization duration: Through end of plan 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, for the temporary relief of pain associated with minor burns, sunburn, abrasions of the skin, and insect bites, and for topical anesthesia
- Covered when used in a compound for an FDA- approved indication or when used for topical anesthesia **AND** all active ingredients in the compounded product are FDA approved for topical use

Authorization duration: 3 months

Coverage criteria for lidocaine/prilocaine 2.5%/2.5% CREAM:

- Covered when being used for topical anesthesia that is not related to dialysis services
- Covered when used in a compound for an FDA- approved indication or when used for topical anesthesia that is not related to dialysis services **AND** all active ingredients in the compounded product are FDA approved for topical use

Authorization duration: 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 ☐ Male ☐ Female	Patient date of birth	M.D. office fax number	

Diagnosis and medical information			
Medication requested ☐ lidocaine 5% **PATCH** (generic Lidoderm) ☐ lidocaine 5% **OINTMENT** ☐ lidocaine/prilocaine 2.5%/2.5% **CREAM**		**Frequency**	
New prescription OR date therapy initiated	**Quantity**	**Day supply**	**Expected length of therapy**

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Diagnosis and medical information *(continued)*

Diagnosis (*Please check ALL boxes that apply and include all office notes supporting diagnosis.)*

For lidocaine 5% PATCH:

☐ Post-herpetic neuralgia ☐ Diabetic neuropathy ☐ Cancer-related neuropathy (including treatment-related neuropathy, such as neuropathy associated with radiation treatment or chemotherapy)

☐ Other diagnoses/ICD 10 codes: _____

For lidocaine 5% OINTMENT:

☐ Topical anesthesia
☐ Temporary relief of pain associated with minor burns, sunburn, abrasions of the skin, or insect bites
☐ Production of anesthesia of accessible mucous membranes of the oropharynx (part of the throat)
☐ Anesthetic lubricant for intubation (e.g. placement of a breathing tube)
☐ Other diagnoses/ICD 10 codes: _____

For lidocaine/prilocaine 2.5%/2.5% CREAM:

☐ Topical anesthesia on normal intact skin for local analgesia
☐ Topical anesthesia on genital mucous membranes for superficial minor surgery or pretreatment for infiltration anesthesia
☐ Topical anesthesia
☐ Other diagnoses/ICD 10 codes: _____

If requesting lidocaine PATCH, please answer questions 1-3 AND 13-14

If requesting lidocaine OINTMENT, please answer questions 4-7 AND 13-14

If requesting lidocaine/prilocaine CREAM, please answer questions 8-12 AND 13-14

If requesting lidocaine PATCH, please answer questions 1-3 AND 13-14
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.

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If requesting lidocaine OINTMENT, please answer questions 4-7 AND 13-14
Please check ALL boxes that apply for lidocaine 5% OINTMENT:

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

INGREDIENT NAME	PRODUCT NDC	QUANTITY

5. ☐ 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.

6. ☐ 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.

7. ☐ 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.

If requesting lidocaine/prilocaine CREAM, please answer questions 8-12 AND 13-14
Please check ALL boxes that apply for lidocaine/prilocaine CREAM:

8. ☐ Yes ☐ No Is the patient currently on dialysis or will the patient be starting dialysis soon?
☐ Yes ☐ No Will the lidocaine/prilocaine **CREAM** be used for a dialysis-related condition?

9. ☐ Lidocaine/prilocaine 2.5%/2.5% **CREAM** is being used as part of a compounded product combined with the following ingredients:

INGREDIENT NAME	PRODUCT NDC	QUANTITY

10. ☐ 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.

11. ☐ 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.

12. ☐ Yes ☐ No **Lidocaine/prilocaine 2.5%/2.5% CREAM has a quantity limit of 30 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):

13. ☐ **Please list all medications the patient has tried specific to the diagnosis and specify below.**

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

14. ☐ **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**