Prior Authorization Form

Lidoderm

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-582-2038** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Lidoderm.

Drug Name (select from list of drugs shown)

Lidocaine Patch 5% Lidoderm (lidocaine patch 5%) ZTlido (lidocaine patch 1.8%)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

**Diagnosis:** _____ **ICD Code:** _____

Comments: _____

**Please circle the appropriate answer for each question.**

| | | |
|---|---|---|
| 1. | Is the requested drug being prescribed for any of the following: A) Pain associated with post-herpetic neuralgia, B) Pain associated with diabetic neuropathy, C) Pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g. neuropathy associated with radiation treatment or chemotherapy])? | Y N |
| 2. | Does the patient require more than the plan allowance of 90 patches per month? | Y N |

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 the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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| **Prescriber (Or Authorized) Signature and Date** |