carolina complete health

Pharmacy Request for Prior Approval - Lidoderm

Recipient Information

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: **Lidoderm** 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

Clinical Information

1. Has the recipient tried and failed on Voltaren Gel? ☐ Yes ☐ No

2. Is the patient diagnosed with Post-Herpetic Neuralgia? ☐ Yes ☐ No

3. Does the recipient have a diagnosis of Neuropathic pain? ☐ Yes ☐ No

   3a. Does the recipient have a documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressant, SSRI's, SNRI's, anticonvulsants, NSAID's, or COXII's?
   ☐ Yes ☐ No List: _____

4. Does the recipient have a diagnosis of Chronic musculo-skeletal pain for greater than 6 months duration?
☐ Yes ☐ No

   4a. Does the recipient have a documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressant, SSRI's, SNRI's, anticonvulsants, NSAID's, or COXII's?
   ☐ Yes ☐ No List: _____

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309