PriorityHealth

Pharmacy
Prior Authorization Form

Last Reviewed: Nov 11

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: ☐ **Commercial Plan** ☐ **Medicaid Plan** ☒ **Medicare Plan**

Lidoderm Patch® (lidocaine)

☐ Urgent ☐ Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

☐ Lidoderm Patch 10 X 14

Dose: ____ Start date: _____________________

Priority Health Precertification Requirements:

Authorization for Lidoderm requires:

- Diagnosis of postherpetic neuralgia

Please Complete the Following Information:

Diagnosis:

☐ Postherpetic Neuralgia (shingles)

☐ Other: ________________________

Please provide rationale for use: ____

Note*:* There is not reliable evidence that Lidoderm patches are effective for treating pain that is not associated with postherpetic neuralgia. Requests for non-FDA approved indications will not be authorized.

Authorization and limitation:

- When approved, authorization will be limited to two months of therapy initially.
- If the pain associated with postherpetic neuralgia is still present after two months of therapy with Lidoderm patches, an additional one month of therapy will be approved.
- Subsequent authorizations will be for one month of therapy, if pain persists.

PriorityHealth

FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. ☐ All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. ☐ The number of doses available under a dose restriction for the prescription drug:
   - **a.** ☐ Has been ineffective in the treatment of the enrollee's disease or medical condition, or
   - **b.** ☐ Based on 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.
3. ☐ The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
   - **a.** ☐ Has been ineffective in the treatment of the enrollee's disease or medical condition, or
   - **b.** ☐ Based on 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.
   - **c.** ☐ Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. ☐ None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX