

TOPICAL LIDOCAINE PRIOR AUTHORIZATION PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis:

- Analgesia for superficial dermatological procedures such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal
- Anesthesia of accessible mucous membranes of the oropharynx
- Anesthetic lubricant for intubation
- Temporary relief of pain associated with minor burns, including sunburn, abrasions of the skin, and insect bites
- Pain associated with post-herpetic neuralgia (PHN)
- Neuropathic pain associated with cancer or cancer treatment
- Other (ICD code plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? Yes No
 If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.**..... Yes No
2. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No
 If no, has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer?
 Please note, chart notes are required. Yes No
 If yes, please submit chart notes.
 If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No
 If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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3. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
If yes, please specify contraindication(s): _____

4. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please submit chart notes to support the answers to the following questions:

5. Has the patient tried and had an inadequate response to over-the-counter topical lidocaine? Yes No

6. Was over-the-counter topical lidocaine discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No

7. Does the patient have an intolerance or hypersensitivity to over-the-counter topical lidocaine that is not expected to occur with the requested agent?..... Yes No

8. Does the patient have an FDA labeled contraindication to ALL over-the-counter topical lidocaine that is not expected to occur with the requested agent?..... Yes No

9. Is over-the-counter topical lidocaine expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No

10. Is over-the-counter topical lidocaine not in the best interest of the patient based on medical necessity? Yes No

11. Has the patient tried another drug in the same pharmacologic class or with the same mechanism of action as over-the-counter topical lidocaine and that drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No

12. Is there information that indicates over-the-counter topical lidocaine is not clinically appropriate? Yes No
If yes, please explain: _____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
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BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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