AMIDACARE EXPRESS SCRIPTS®

Prior Authorization Form
Lidoderm 5% Transdermal Patch

This form is based on Express Scripts standard criteria and may not be applicable to all patients; Amida Care may require additional information beyond what is specifically requested.

Fax completed form to **1-800-357-9577**

If this an **URGENT** request, please call 1-800-753-2851

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:

1. What is the indication or diagnosis?

- ☐ Carpal Tunnel Syndrome
- ☐ Low Back pain
- ☐ Myofascial pain
- ☐ Neurophatic pain
- ☐ Postherpetic Neuralgia (PHN – pain that occurs after a shingles outbreak)
- ☐ Osteoarthritis (OA)
- ☐ Other: _____

2. For Myofascial pain diagnosis only, will the Lidoderm Patch be used in combination with a standard myofascial trigger point (MTP) treatment modality?	☐ Yes	☐ No	☐ N/A
3. For low back pain diagnosis only, has the patient tried three other pharmacologic therapies commonly used to treat low back pain? If yes, please list other pharmacological therapies tried: _____	☐ Yes	☐ No	☐ N/A
4. For Carpal Tunnel Syndrome diagnosis only, has the patient tried one other pharmacological therapy used to treat carpal tunnel syndrome (e.g., steroids [oral or injectable], NSAIDs)? If yes, please list other pharmacological therapies tried: _____	☐ Yes	☐ No	☐ N/A

5. For Osteoarthritis (OA) diagnosis only, has the patient tried at least three other pharmacologic therapies used to treat osteoarthritis (OA)? If yes, please list other pharmacologic therapies tried: _____	☐ Yes	☐ No	☐ N/A

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

_____

_____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to Amida Care for the detailed information regarding benefits, conditions, limitations, and exclusions.

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