

Lidoderm[®] (lidocaine) Patch Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			P	Provider Information (required)			
Member Name:			Provider Name	Provider Name:			
Insurance ID#:			NPI#:		Specialty:		
Date of Birth:		Office Phone:	Office Phone:				
Street Address:		Office Fax:	Office Fax:				
City:	State:	Zip:	Office Street A	Office Street Address:			
Phone:			City:	State:		Zip:	
Medication Information (required)							
Medication Name:			Strength:	Dosage Form:		orm:	
Check if requestin	g brand	Directions for	Directions for Use:				
Check if request is	s for continuation of						
Clinical Information (required)							
Select the diagn	iosis below: neuralgia (PHN)						
Other diagnosis:			ICD-10 Code(s):				
Are there any other co this review?	omments, diagnoses	, symptoms, medications	tried or failed, and/or a	any other informatior	n the physicia	an feels is important to	

Please note:

This request may be denied unless all required information is received. For urgent or expedited requests please call 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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