Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Lidoderm

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Lidoderm.

Drug Name (select from list of drugs shown)

Lidocaine Patch 5% Lidoderm (lidocaine patch 5%)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is lidocaine patch being prescribed for any of the following: A) Pain associated with post-herpetic neuralgia, B) Pain associated with diabetic neuropathy, C) Pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g. neuropathy associated with radiation treatment or chemotherapy])?	Y N
2.	Does the patient require more than 90 patches per month (or 270 patches per 3 months)?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date