Prior Authorization Form

CAREMARK FAX FORM

Lidoderm

This fax machine is located in a secure location as required by HIPAA regulations.
Complete information, sign and date. Fax completed forms to Caremark at 888-836-0730

Please contact Caremark @ 888-414-3125 with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Lidoderm

Drug Name: _____

Patient:
Patient Name: _____
Patient ID: _____
Patient Group Number: _____
Patient Date Of Birth: _____

Prescribing Physician:

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician _____
Physician City, State, Zip: _____

Diagnosis: **ICD 9 code:**

Please circle the appropriate answer for each applicable question.

1	Does the patient have the diagnosis of pain associated with post-herpetic neuralgia?	Y	N
2	Is the skin intact (not broken, nor inflamed) where the patch is to be applied?	Y	N
3	Does the patient have sensitivity to local anesthetics of the amide type (e.g., procaine, tetracaine, benzocaine)?	Y	N

Comments: _____

Information given on this form is accurate as of this date.

_____

Prescriber or Authorized Signature