UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Topical Lidocaine

Patient name:_________________________ Medicaid ID #:_________________________
Prescriber Name:_________________ Prescriber NPI#:____________ Contact person:____________________
Prescriber Phone#:___________________ Extension/Option:________________ Fax#:____________________
Pharmacy:______________________ Pharmacy Phone#:____________ Pharmacy Fax #:____________
Requested Medication:______________________________ Strength:__________ Frequency:____________

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992

CRITERIA:

Transdermal lidocaine patches (Lidoderm®)
- Patient diagnosis must be postherpetic neuralgia or other peripheral neuropathy. Please indicate the diagnosis code: ________________
- Maximum of 90 patches per 30 day time period
- Authorization:
  - Initial authorization: 6 months
  - Reauthorization: 1 year upon submittal of a letter from the prescriber indicating drug effectiveness

Viscous lidocaine solutions:
- Patients must be > 3 years old
- Authorization:
  - Initial authorization: One prescription fill
  - Reauthorization: 3 months upon submittal of a letter from the prescriber indicating drug effectiveness and rationale for continuing therapy

All other topical lidocaine containing products:
- Maximum of 60g container topical lidocaine
- Authorization:
  - Initial authorization: One prescription fill
  - Reauthorization: 3 months upon submittal of a letter from the prescriber indicating drug effectiveness and rationale for continuing therapy

12/10/2015

https://medicaid.utah.gov/pharmacy/