



NC DHB Pharmacy Request for Prior Approval - Lidoderm

DMA-3104 (V.01)

Recipient Information

1. Recipient Last Name: _____ 2. First Name: _____
3. Recipient ID #: _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:

8. Prescriber DEA #: _____

Requester Contact Information

Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: **Lidoderm** 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other: _____

Clinical Information

1. Has the recipient tried and failed on Voltaren Gel? Yes No

2. Is the patient diagnosed with Post-Herpetic Neuralgia? Yes No

3. Does the recipient have a diagnosis of Neuropathic pain? Yes No

3a. Does the recipient have a documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressant, SSRI's, SNRI's, anticonvulsants, NSAID's, or COXII's?

Yes No List: _____

4. Does the recipient have a diagnosis of Chronic musculo-skeletal pain for greater than 6 months duration?

Yes No

4a. Does the recipient have a documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressant, SSRI's, SNRI's, anticonvulsants, NSAID's, or COXII's?

Yes No List: _____

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to NCTracks at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505