



## NC DMA Pharmacy Request for Prior Approval - Lidoderm

### Recipient Information

DMA-3104 (V.01)

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 CSC at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505