OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Lidoderm® (lidocaine patch) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Continuation of therapy:

Is this a continuation of prior therapy? ❑ **Yes** ❑ **No**

If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: (**REQUIRED)**

_____

_____

Select the diagnosis below:

❑ Pain associated with post-herpetic neuralgia

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Has the patient had prior use of ONE of the following alternatives or are the listed alternatives contraindicated, inappropriate, or ineffective for this patient: Diclofenac, etodolac, fenoprofen calcium, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketorolac tromethamine, meclofenamate sodium, mefenamic acid, meloxicam, nabumetone, naproxen, oxaprozin, piroxicam, sulindac, or tolmetin sodium? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

For continuation of existing therapy, also answer the following:

Would sudden discontinuation of the dose trigger withdrawal symptoms? ❑ **Yes** ❑ **No**

Would discontinuation of the dose be unsafe for the patient and their condition may worsen or exacerbate? ❑ **Yes** ❑ **No**

Is the prescribing provider attempting to taper or reduce the dose necessary? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.