UnitedHealthcare Community Plan

# Lidocaine Patch
## Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.**
**Allow at least 24 hours for review.**

**Section A – Member Information**

| First Name: | Last Name: | Member ID: |
|---|---|---|
| Address: | | |
| City: | State: | ZIP Code: |
| Phone: | DOB: | Allergies: |
| Primary Insurance Information (if any): | | |

**Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____**

**Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____**

**Section B - Provider Information**

| First Name: | | Last Name: | | M.D./D.O. |
|---|---|---|---|---|
| Address: | | City: | State: | ZIP code: |
| NPI #: | Phone: | Fax: | Specialty: | |
| Office Contact Name / Fax attention to: | | | | |

**Section C - Medical Information**

| **Medication:** | **Strength:** |
|---|---|
| **Directions for use:** | **Quantity:** |
| **Diagnosis** (Please be specific & provide as much information as possible)**:** | **ICD-10 CODE:** |

**Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____**

**Section D – Previous Medication Trials**

| Medication Name | Strength | Directions | Dates of Therapy | Reason for failure / discontinuation |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives**

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| Member First name: | Member Last name: | Member DOB: |
|---|---|---|

## Clinical and Drug Specific Information

**ALL REQUESTS:**

**- What is the patient's diagnosis? (check which applies)**

□ Post-Herpetic Neuralgia
□ Neuropathic Pain
□ Other. **List diagnosis:** _____

**- Does the patient have a history of failure, contraindication, or intolerance to ALL of the following:**

□ **Tricyclic anti-depressant (e.g., amitriptyline)**
□ **SNRI anti-depressant (e.g., duloxetine, venlafaxine)**
□ **Gabapentin**

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

**Requests for CONTINUATION OF THERAPY:**

**- Does the patient have a documented positive clinical response to lidocaine patch therapy? □ Yes □ No**
**If yes, list response:** _____
_____

**Provider Signature:** _____ **Date:** _____