

Sterling Retiree Rx Prior Authorization Form

LIDODERM (Lidocaine HCl)

Coverage Criteria / Required Medical Information

- A. Diagnosis is documented as post-herpetic neuralgia.
- B. The skin where the patch is to be applied is intact (not broken or inflamed).
- C. The patient has completed a documented one month trial and failure of the following two medications: gabapentin and Lyrica **or**
- D. The patient has a contraindication or has demonstrated an adverse event to the prerequisite drugs.

Coverage Duration: 3 months

Member Information

Name				
Enrollment/Card-holder ID Number				
Group/Plan		Male	Female	
Date of Birth		Age	Weight in Kg	
Street Address				
City		State	Zip	

Physician Information

Name				
Agent		Contact Name		
Specialty/Office				
Clinic Name				
Street Address				
City		State	Zip	
Phone		Fax		

Requested Drug

LIDODERM	Reason for Request
Condition/Diagnosis Related	

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing		Strength/Dosage	
Formulary Alternative(s) Attempted?		Yes:	No:
Please List Alternative Formulary Drugs			

Comments

Physician Signature: _____ Fax Form to 1-866-481-3704