



# Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

## Lidocaine Patch (Lidoderm®) Prior Authorization Request Form

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

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

Clinical Information (required)
<p><b>Select the diagnosis below:</b></p> <p><input type="checkbox"/> Herpes Zoster (no PA required if the corresponding ICD-10 code for this diagnosis is documented on the prescription and transmitted on the claim)</p> <p><input type="checkbox"/> Post Herpetic Neuralgia/Neuropathy</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p><b>Clinical information:</b></p> <p>Has the recipient experienced therapeutic failure of TWO different preferred medications within the same drug class? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>yes</b>, please list ALL medications and dates of trial: _____</p> <p>Does the recipient have an allergy, contraindication, drug-to-drug interaction, or a history of unacceptable/toxic side effects with ALL preferred medications within the same drug class? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>yes</b>, please list ALL medications and allergy/contraindication/interaction/side effects: _____</p> <p>_____</p> <p>Is the non-preferred medication being requested because it is being used for a unique indication that is supported by peer-reviewed literature or an FDA-approved indication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>yes</b>, please list the unique indications: _____</p> <p>_____</p>

**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.

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