Updated: 08/2023
DMMA Approved: 08/2023

Request for Prior Authorization for Lidocaine Topical Patch (Lidoderm 5%)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Lidocaine Topical Patch (Lidoderm 5%) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Lidocaine Topical Patch (Lidoderm 5%) Prior Authorization Criteria:

Claims will automatically adjudicate on-line without a requirement to submit for prior authorization when the following criteria is met:

- A diagnosis of postherpetic neuralgia is entered at the point of sale.
- A diagnosis of diabetic peripheral neuropathy is entered at the point of sale and the following criteria is met:
    - Pharmacy claims data confirming a trial and failure of ONE of the following within the past 90 days
        - An antidepressant (e.g. nortriptyline, amitriptyline, desipramine, duloxetine)
        - Gabapentin or pregabalin
    - If pharmacy claims data cannot confirm the above medications trials documentation must be submitted showing the member has a history of trial and failure, contraindication, or intolerance to ONE of the following:
        - An antidepressant (e.g. nortriptyline, amitriptyline, desipramine, duloxetine)
        - Gabapentin or pregabalin

- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Members with historical pharmacy claims data meeting the following criteria will receive automatic reauthorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the reauthorization criteria below. Claims will automatically adjudicate on-line, without a requirement to submit for reauthorization when the following criteria is met:
        - Documentation the member has been on lidocaine 5% patch within the last 180 days
- **Reauthorization Duration of approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

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Lidocaine Topical Patch (Lidoderm 5%)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Health Options ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

1. What is the diagnosis?
   - ☐ Postherpetic neuralgia.
   - ☐ Diabetic peripheral neuropathy
   - ☐ Other: _____
2. What has been tried (please describe below)?
   - ☐ An antidepressant (e.g. nortriptyline, amitriptyline, desipramine, duloxetine)
   - ☐ Gabapentin or pregabalin (Lyrica)

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member been on lidocaine 5% patch within the last 180 days? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature Date

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