Lidoderm® Prior Authorization Worksheet
New York State Medicaid Clinical Drug Review Program

## Program Information

* Drugs included in the Clinical Drug Review Program require prior authorization.
* A list of CDRP drugs is available at [www.nyhealth.gov](http://www.nyhealth.gov) and at [http://newyork.fhsc.com](http://newyork.fhsc.com/).
* Fax requests are NOT permitted for some CDRP drugs.

## Prescriber Procedure

* If your fax includes the standardized fax form, only the Member Name, ID, DOB, and Clinical Criteria need to be completed and faxed as an attachment to process your request.
* PA requests from 3rd party agencies to include faxes or any media are not allowed.  Please have the prescribing physician or an agent employed by the prescribing practitioner contact our department for consideration of this request.

*If your fax includes the standardized fax form, only the Member Name, ID, DOB, and Clinical Criteria need to be completed and faxed as an attachment to process your request.*

| Enrollee Information |
| --- |
| Enrollee Name:      | Date of Birth:      |
| enrollee medicaid id number (2 letters, 5 numbers, 1 letter):      |

| Prescriber Information |
| --- |
| prescriber Name:      | contact person:      |
| prescriber 10-digit national provider identifier (NPI):      | office Phone Number:      | office Fax number:      |

| Clinical Criteria |
| --- |
| Drug name: | Lidoderm® |
| Directions: |       |
| Quantity: |       |
| Refills: |       |
| New prescription: | [ ]  Yes [ ]  No | If No, Date Therapy Initiated: |       |
| expected length of therapy: |       |
| diagnosis:      | Date of initial diagnosis (if post herpetic neuralgia or herpes zoster):      |

| Medication History |
| --- |
| Please provide medications used to treat diagnosis. |
| Medication  | Date of Therapy | Strength | Frequency |
|  | Start Date | End Date |  |  |
|       |       |       |       |       |
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| Lidoderm® is only FDA approved to be prescribed for Post Herpetic Neuralgia. If you are using it for off-label use, please provide clinical rationale for why the patient is unable to use conventional medications used to treat that diagnosis. |
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|       |

I attest that Lidoderm® is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by New York Medicaid.

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| --- | --- | --- |
|  |  |       |
| Prescriber Signature |  | date |