

# Lidoderm Patch Prior Authorization Form

**START HERE**

**Member &  
Prescriber  
Information**

Member Name:	Prescriber Name:
	Prescriber Specialty:
Member Date of Birth:	Prescriber Phone #:
Member ID #:	Prescriber Fax #:

**Criteria**

Lidoderm is approvable for the following conditions:

1. Post herpetic neuralgia
2. Peripheral neuropathy

Lidoderm patches can be cut with scissors before removing the adhesive liner.

Quantity limit of 30 patches per month.

Attach clinic notes to support request and document trials of prior therapy.

**Diagnosis:**

**Recalcitrant peripheral neuropathy**

Must have tried at least 1 agent from each column (check all that apply)

Antidepressant	Anti-Convulsant	Analgesics/Other
<input type="checkbox"/> Amitriptyline	<input type="checkbox"/> Carbamazepine	<input type="checkbox"/> APAP combo with opiates
<input type="checkbox"/> Desipramine	<input type="checkbox"/> Divalproex	<input type="checkbox"/> Morphine (IR and ER)
<input type="checkbox"/> Duloxetine (Cymbalta)	<input type="checkbox"/> Ehtosuximide	<input type="checkbox"/> NSAIDS (at least 2 classes)
<input type="checkbox"/> Nortriptyline	<input type="checkbox"/> Felbatol	<input type="checkbox"/> Oxycodone (IR and ER)
<input type="checkbox"/> Paroxetine	<input type="checkbox"/> Lamotrigine	<input type="checkbox"/> Cyclobenzaprine
<input type="checkbox"/> Sertraline	<input type="checkbox"/> Levitracetam	<input type="checkbox"/> Mexilitene
	<input type="checkbox"/> Oxcarbazepine	<input type="checkbox"/> Capsaicin
	<input type="checkbox"/> Phenytoin	

**Post herpetic neuralgia**

Must have tried 1 agent in each column

Antidepressant (at least 1)	Anti-Convulsant (at least 1)
<input type="checkbox"/> Amitriptyline	<input type="checkbox"/> Carbamazepine
<input type="checkbox"/> Duloxetine (Cymbalta)	<input type="checkbox"/> Divalproex
<input type="checkbox"/> Nortriptyline	<input type="checkbox"/> Gabapentin
<input type="checkbox"/> Paroxetine	<input type="checkbox"/> Oxcarbazepine
	<input type="checkbox"/> Other:

**Choose  
Product**

**Lidoderm** (please select desired monthly quantity)

- 15 patches
- 30 patches
- 45 patches (provide additional justification):

**Sign/Date &  
Mail or Fax**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Prescriber NPI:** \_\_\_\_\_

**Mailing Address**

Physicians Plus Insurance Corporation  
Attn: Pharmacy Services  
P.O. Box 2078  
Madison WI 53701-2078

**Physicians Plus Pharmacy Services Fax:**

(608) 258-1905

**Prior Authorization Questions?**

(608) 260-7803 or (800) 545-5015 (ext. 7803)

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