**OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.**
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# Lidoderm® (lidocaine) patch Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.**

This form may be faxed to 844-403-1029.

| 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: |
| | Directions for Use: | |

## Clinical Information (required)

1. Select the diagnosis below:
   - ❑ Pain associated with cancer-related neuropathy [including treatment-related neuropathy (e.g., neuropathy associated with radiation treatment or chemotherapy)]
   - ❑ Pain associated with diabetic neuropathy
   - ❑ Pain associated with post-herpetic neuralgia
   - ❑ Other diagnosis: _____ ICD-10 Code: _____

*Information on this form is accurate as of this date.*

| **Prescriber's Signature:** | **Date:** |
|---|---|
| | |

**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 more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern