UnitedHealthcare Community Plan

Lidocaine Patch

PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

This form contains multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____

If continuation, has the patient had a positive clinical response to therapy? □ Yes □ No

If yes, list response: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:		Last Name: M.D./D.O.	
Address:		City:	State: ZIP code:
Phone:	Fax:	NPI #:	Specialty:

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

- Does the patient have a history of failure, contraindication or intolerance to any of the following? □ Yes □ No

□ Tricyclic anti-depressant □ SNRI anti-depressant □ Gabapentin

(If any, please complete Section D below with medication information)

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Explanation of why preferred medications would not meet the patients needs

Section F – Quantity Limit Requests

- Is there a reason why a greater quantity of medication is required to treat the patient's condition? □ Yes □ No

If yes, list reason: _____

Physician Signature: _____ Date: _____