

Clinical Pharmacy Program Guideline for Lidoderm

Program	Prior Authorization
Medication	Lidoderm (lidocaine patch 5%)
P&T Approval Date	12/17/2015, 11/2016
Effective Date	1/2017

1. Background:

Lidoderm is indicated for relief of pain associated with post-herpetic neuralgia.

2. Coverage Criteria:

<p>A. Lidoderm will be approved based on the following criteria:</p> <p>1. Diagnosis of post-herpetic neuralgia</p> <p>Authorization will be issued for 6 months.</p>

3. References:

1. Lidoderm [package insert]. Malvern, PA: Endo Pharmaceuticals Inc.; January 2015.
2. Dubinsky RM, Kabbani H, El-Chami, Z, et al. Practice Parameter: Treatment of postherpetic neuralgia. *Neurology*. 2004; 63: 959-65.
3. Dworkin RH, Johnson RW, Breuer J, et al. Recommendations for the Management of Herpes Zoster. *Clinical Infectious Diseases*. 2007; 44: S1-S26.



HISTORICAL CHANGE NOTES:

<u>Date</u>	<u>Summary of Change</u>	<u>Reason for Change</u>
June 2010	New drug policy	
March 2011	Annual Review	No Change
March 2012	Annual Review	No Change
March 2013	Annual Review	No Change
Dec 2015	Annual Review	No Change
Oct 2016	Annual Review	Template update, no change to policy

APPROVALS:

<u>Date</u>	<u>Approved by</u>
6/10/2010	P&T Committee
7/26/2010	PARP
3/10/2011	P&T Committee
4/25/2011	PARP
3/08/2012	P&T Committee
5/21/2012	PARP
3/21/2013	P&T Committee
5/20/2013	PARP
11/30/2015	PARP
12/17/2015	P&T Committee