PRIOR AUTHORIZATION REQUEST

ZTLIDO

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this a request for INITIAL or CONTINUATION of therapy with the requested medication? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No

If you have any questions, call: 1-888-258-8250

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
8	What is the diagnosis or indication? [] Post-herpetic neuralgia (If checked, go to 9) [] Diabetic peripheral neuropathy (DPN) (If checked, no further questions) [] Other (If checked, no further questions)		
9	Has the patient tried and failed or had an inadequate treatment response to gabapentin for at least 3 months? [If no, no further questions]	Yes	No
10	Has the patient tried and failed or had an inadequate treatment response to pregabalin for at least 3 months? [If no, no further questions]	Yes	No
11	Does the patient have a documented inadequate treatment response to generic lidocaine 5% patch for at least 3 months despite appropriate use? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 13.]	Yes	No
12	Does the patient have a documented intolerance or contraindication to generic lidocaine 5% patch? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions]	Yes	No
13	Does the requested dose exceed the Food and Drug Administration (FDA)	Yes	No

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approved label dosing for the requested indication? Note: Dosing is one patch daily for 12 hours on and 12 hours off.

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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