

## Iowa Department of Human Services

## Hawki lowa HHS

## Request for Prior Authorization LIDOCAINE PATCH

**Provider Help Desk** 1 (844) 236-1464

(PLEASE PRINT – ACCURACY IS IMPORTANT)

**FAX Completed Form To** 1 (877) 733-3195

IA Medicaid Member ID #	Patient name			DOB				
Patient address								
Provider NPI	Prescriber name			Phone				
Prescriber address				Fax				
Pharmacy name Address			Phone					
Prescriber must complete all informa	ition above. It must be legi	ble, correct, and c	omplete or fo	orm will b	e returi	ned.		
Pharmacy NPI	Pharmacy fax		NDC					
Prior authorization is required for there is a diagnosis of pain asso with the initial prescription to def	ciated with post-herpetic							
Preferred  ☐ Lidocaine 5% Patch	Non-Preferred Lidoderm	☐ ZTlido						
_		_						
Dosage Ins	_	Quantity	Days :	Supply				
Dosage Ins	_	Quantity	Days :	Supply	_			
Dosage Ins	structions		Days :	Supply	_			
	structions				_			
Diagnosis:	structions				_			

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.