



Nevada Medicaid – Molina Healthcare

Lidocaine Patch (Lidoderm®)

Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Molina ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:		State:
			Zip:		

Medication Information <small>(required)</small>		
Medication Name:		Strength:
<input type="checkbox"/> Check if requesting brand		Dosage Form:
<input type="checkbox"/> Check if request is for continuation of therapy		Directions for Use:

Clinical Information <small>(required)</small>
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Herpes Zoster (no PA required if the corresponding ICD-10 code for this diagnosis is documented on the prescription and transmitted on the claim)</p> <p><input type="checkbox"/> Post Herpetic Neuralgia/Neuropathy</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>Clinical information:</p> <p>Has the recipient experienced therapeutic failure of TWO different preferred medications within the same drug class? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please list ALL medications and dates of trial: _____</p> <p>Does the recipient have an allergy, contraindication, drug-to-drug interaction, or a history of unacceptable/toxic side effects with ALL preferred medications within the same drug class? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please list ALL medications and allergy/contraindication/interaction/side effects: _____</p> <p>_____</p> <p>Is the non-preferred medication being requested because it is being used for a unique indication that is supported by peer-reviewed literature or an FDA-approved indication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please list the unique indications: _____</p> <p>_____</p>

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 urgent or expedited requests please call (833) 685-2103.
 This form may be used for non-urgent requests and faxed to (844) 259-1689.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Molina Healthcare. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.** Office use only: Lidoderm-lidocainepatch_NevadaMedicaid_2019Jul-W
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