



**Prescription Drug Coverage Determination Form**  
Topical Analgesia  
Lidoderm® (transdermal lidocaine)

Please fax the completed form to Mercy Health Plans' Pharmacy Department  
at 314-214-8201 or 1-800-466-9854.

**Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Physician Information**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person \_\_\_\_\_

Physician Signature (REQUIRED): \_\_\_\_\_ Date \_\_\_\_\_

Medication Information (requests for non-formulary agents will be considered for  
members having a documented failure or contraindication to preferred agents.)

Medication name: \_\_\_\_\_ J-code: \_\_\_\_\_  
Dose: \_\_\_\_\_ Directions: \_\_\_\_\_  
Expected Duration of Therapy: \_\_\_\_\_

**Prior Authorization Criteria:**

1. Is medication being requested to treat an FDA-approved indication  
not otherwise excluded from Part D?  Yes  No  
Diagnosis: \_\_\_\_\_ ICD-9 code \_\_\_\_\_
2. Does the patient have a history of sensitivity to local anesthetics  
of the amide type (e.g., procaine, tetracaine, benzocaine)?  Yes  No
3. Is the skin broken or inflamed in the area where the patch will be  
applied?  Yes  No

Please provide any additional history or medical information that may support coverage  
(attach office notes as necessary): \_\_\_\_\_

Note: If approved coverage will be as specified in above criteria or through the end of the  
year (December 31, 20xx). Some medications may be subject to quantity limitations or  
restricted to certain pharmacies.