Prescriber Criteria Form
Lidocaine Patch 2026 PA Fax 1433-A v1 010126.docx
Lidocaine Products
Lidocan, Lidoderm, Tridacaine (lidocaine patch 5%), Lidotral 1 (lidocaine patch 4.88%), Ztlido (lidocaine topical system)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Lidocaine.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for pain associated with post-herpetic neuralgia (PHN)? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for pain associated with diabetic neuropathy? [If yes, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy])?	Yes	No

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____