Prescriber Criteria Form

Lidocaine Topical 2025 PA Fax 1434-A v1 010125.docx
Glydo (lidocaine HCl urethral/mucosal 2% gel), Lidocaine HCl 4% Solution, Lidocaine 5% Ointment, Lidogel (lidocaine HCl 2.8% gel), Lidorex (lidocaine HCl 2.8% gel), Pliaglis (lidocaine and tetracaine 7-7% cream), Synera (lidocaine and tetracaine 70-70mg patch)
The requested product is covered by a bundled payment benefit under Medicare Part B and is not subject to the criteria contained in this document when the drug is being used for a dialysis-related condition for a patient who is undergoing dialysis
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 Topical.

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 used for topical anesthesia? [If no, then no further questions.]	Yes ◯	No ◯
2	Will the requested drug be used as part of a compounded product? [If no, then no further questions.]	Yes ◯	No ◯
3	Are all the active ingredients in the compounded product Food and Drug Administration (FDA) approved for topical use?	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:**_____