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Magellan Rx MANAGEMENT℠

NYRx the Medicaid Pharmacy Program

Lidocaine Patch Prior Authorization Worksheet

Fax Number: 1-800-268-2990

Processing may be delayed if information submitted is illegible or incomplete. If your fax includes the standardized fax form, only the **Member Name**, **DOB**, **ID**, and **Clinical Criteria** need to be completed and faxed as an attachment to process your request.

ENROLLEE INFORMATION

Enrollee's Last Name: _____

Enrollee's First Name: _____

Date of Birth: _____

Enrollee's Medicaid ID (2 letters, 5 numbers, 1 letter): _____

PRESCRIBER INFORMATION

Prescriber's Last Name: _____

Prescriber's First Name: _____

National Provider Identifier (NPI) Number: _____

Board Certified Specialty: _____

Prescriber's Street Address: _____

City: _____

State: _____ **Zip Code** _____

Prescriber's Phone Number: _____

Prescriber's Fax Number: _____

REQUESTED DRUG INFORMATION

Drug Name: _____ **Drug Strength:** _____

Quantity: _____ **Refills:** _____

Directions: _____

New Prescription: ☐ Yes ☐ No If **NO**, date therapy was initiated: _____

Expected length of therapy: _____

Enrollee's Last Name: **Enrollee's First Name:**

CLINICAL CRITERIA

Diagnosis: _____

Date of Initial Diagnosis (if post herpetic neuralgia or herpes zoster): _____

MEDICATION HISTORY

1. Please provide medications used to treat diagnosis:

Medication	Therapy Start Date	Therapy End Date	Strength	Frequency

2. Lidocaine patch is only FDA approved to be prescribed for Post Herpetic Neuralgia. If you are using it for off-label use, please provide clinical rationale for why the patient is unable to use conventional medications to treat that diagnosis:

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

Fax Number: 1-800-268-2990
Prior Authorization Call Line: 1-877-309-9493
Billing Questions: 1-800-343-9000

For clinical questions or Clinical Drug Review Program questions, please visit http://newyork.fhsc.com or call 1-877-309-9493.