

APPLIES TO COMMERCIAL AND MEDICAID
Health New England
Medication Request Form (MRF)
Lidoderm[®] (lidocaine 5% topical patch)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Lidoderm[®]. Please complete this form and fax to MedMetrics Health Partners at (800) 550-9246. If you have any questions regarding this process, please contact MedMetrics clinical call center at (866) 209-1057.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information	Physician Information
Patient Name (required):	Physician Name: Specialty:
Patient HNE ID# (required):	HNE Provider #:
Patient Date of Birth (required):	DEA # (required):
Allergies:	Area Code and Telephone #: () -
	Area Code and Fax # (required): () -

Drug Information		
Requested Drug / Strength:	Lidoderm[®]	
Dose, directions and length of treatment (please be specific):	Quantity (per month):	Refills:
Physician signature:	Date:	
Indication:		
<input type="checkbox"/> Post herpetic neuralgia <input type="checkbox"/> Neuropathic pain (peripheral neuropathy due to diabetes, RSD, MS, HIV/Hep C, pain due to cancer, stroke, trauma or spinal cord injury) <input type="checkbox"/> Chronic musculo-skeletal pain (greater than 6 months in duration) <input type="checkbox"/> Documented trial and failure of at least two of the following drug categories: Tricyclic antidepressants, SSRI's, SNRI's, Anticonvulsants, NSAIDs, Opioid analgesics <input type="checkbox"/> Other (please describe): _____ _____ _____ _____		