QualityHealthPlans of new york

Attention: ACTION REQUESTED
Prior Authorization DENIAL may occur unless complete information is provided

Reference: [PA#]

General Prior Authorization Form: Lidoderm

FAX COMPLETED FORM TO QHP PHARMACY DEPT. Fax # 877-817-0842

Coverage Criteria:

-Covered Uses: All medically accepted indications not otherwise excluded from Part D.
-Required Medical Information: Post-herpetic neuralgia: Diagnosis of post-herpetic neuralgia
-Coverage Duration: 12 months

Member Information	Prescriber Information	
Patient Name:	Prescriber Name:	
Member ID#	NPI or DEA#:	
DOB:	Office Phone:	Office Fax:
Address:	Address:	
Home Phone:	Contact Person:	

Medication Information	Medical Information
Medication Requested (drug name, strength and route of administration):	Drug Allergies:
Medication Details (frequency, quantity):	Diagnosis:
Expected Length of Therapy:	Prescriber's Signature/Date:

Rationale for Prior Authorization

1. Does patient have a diagnosis of post-herpetic neuralgia? (check one) ___Yes ___No

2. Please list other medications attempted for this patient:

Medication:	Reason therapy failed:	Length of therapy:
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Additional comments: _____
_____

4. PLEASE INCLUDE RELEVANT MEDICAL RECORDS AND LAB REPORTS WITH YOUR REQUEST.

For Expedited Requests please call 1-877-233-7058
Our Formulary List is located at http://www.qualityhealthplansny.com

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