

Prior Authorization Request Form for
lidocaine-tetracaine 7%-7% topical cream



JOHNS HOPKINS
M E D I C I N E

JOHNS HOPKINS
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

<p>1. Multiple formulary topical local anesthetics are available for DoD beneficiaries without a PA including lidocaine 4% cream, lidocaine 5% cream or ointment, and lidocaine-prilocaine 2.5%-2.5% cream.</p> <p>Does the prescriber acknowledge this preference?</p>	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
<p>2. Is the medication prescribed by or in consultation with a dermatologist or surgeon?</p>	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
<p>3. Will the medication be used in treating back pain or joint pain?</p>	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 4
<p>4. Will the medication be used in compounding?</p>	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 5
<p>5. Will the medication be used as a local anesthetic associated with cosmetic procedures including but not limited to dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal?</p>	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 6

Prior Authorization Request Form for
lidocaine-tetracaine 7%-7% topical cream

6. Please document the clinical rationale of why the patient cannot take any of the formulary topical local anesthetics including lidocaine 4% cream, lidocaine 5% cream or ointment, and lidocaine-prilocaine 2.5%-2.5% cream.

Sign and date below. Note that a new PA is required per prescription fill.

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date

[13 May 2020]

For Internal Use Only

<input type="checkbox"/> Approved:	Duration of Approval: ____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: