Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (MEDICAID)

Lidoderm ZTlido - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Lidoderm ZTlido - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Lidocaine 5% patch   Lidoderm (lidocaine 5% patch)   Ztlido (lidocaine 1.8% topical system)

Quantity   Frequency   Strength

Route of Administration   Expected Length of Therapy

Patient Information
Patient Name: ______________________
Patient ID: ______________________
Patient Group No.: ______________________
Patient DOB: ______________________
Patient Phone:

Prescribing Physician
Physician Name: ______________________
Physician Phone: ______________________
Physician Fax: ______________________
Physician Address: ______________________
City, State, Zip: ______________________

Diagnosis: ______________________ **ICD Code:** ______________________

Comments: ______________________

Please circle the appropriate answer for each question.

1.	Is this request for continuation of therapy?	Y N
	[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]	
	[If no, then skip to question 3.]	
2.	Is the patient showing continued benefit and improvement in pain scale assessment?	Y N
	[Note: Documentation must be submitted.]	

	[No further questions.]		
3.	Does the patient have the documented diagnosis of pain associated with post-herpetic neuralgia?	Y N	
	[Note: Documentation must be submitted.]		
	[If yes, then skip to question 6.]		
4.	Is this request for lidocaine 5 percent patch?	Y N	
	[If no, then no further questions.]		
5.	Does the patient have the documented diagnosis of neuropathic pain associated with traumatic nerve injury, stroke, multiple sclerosis, syringomyelia, spinal cord injury, diabetic neuropathy, or cancer-related neuropathy?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
6.	Has the patient experienced treatment failure or intolerance to medications commonly used to treat the identified diagnosis, or formulary over-the-counter lidocaine 4 percent patch?	Y N	
	[Note: Documentation must be submitted.]		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date