

LIDODERM

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

- Does the patient have the diagnosis of pain associated with post-herpetic neuralgia? Y N
- Is the skin intact (not broken, nor inflamed) where the patch is to be applied? Y N
- Does the patient have sensitivity to local anesthetics of the amide type (e.g., procaine, tetracaine, benzocaine)? Y N
- Is the patch being applied for more than 12 hours in a 24 hour period? Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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