Pharmacy Request for Prior Approval – Topical Local Anesthetics

SANDHILLS CENTER

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: __up to 30 days __60 days __90 days __120 days __180 days __365 days __Other: _____

Clinical Information

1. Does the beneficiary have a diagnosis of post-herpetic neuralgia? Yes___ No___
2. Does the beneficiary have a diagnosis of Neuropathic pain? Yes___ No___ IF yes, please answer 2a.
   2a. Does the recipient have a documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressant, SSRIs, SNRIs, anticonvulsants, NSAIDs, or COXIIs? Yes___ No___
   List drugs tried: _____
3. Does the beneficiary have a diagnosis of Chronic musculo-skeletal pain of greater than 6 months in duration? Yes___ No___
   3a. Does the recipient have a documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressant, SSRIs, SNRIs, anticonvulsants, NSAIDs, or COXIIs? Yes___ No___
   List drugs tried: _____

For Continuation: (answer in addition to the questions above)

4. Has the beneficiary shown continued benefit and improvement or stability in functional status? Yes___ No___

Signature of Prescriber: _____ Date: _____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax to: 1-833-727-3741 or Call PerfomRx for help: 1-888-846-1062