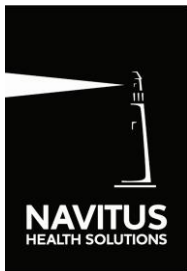




**TEXAS MEDICAID**  
**Clinical Edit Prior Authorization**  
**lidocaine (LIDODERM) 5% patch, ZTLIDO 1.8%**

<b>STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING</b>	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
<b>STEP 2: MEDICATION INFORMATION</b>	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:
Patient's Primary Diagnosis: _____ ICD 10 Code: _____	
Please indicate ONE (1) of the following: <input type="checkbox"/> STAR / STAR KIDS client ( <b>Go to Step 3 - PDL PA Criteria Applies</b> ) <b>OR</b> <input type="checkbox"/> CHIP / PERINATE client ( <b>Go to Step 4</b> )	
<b>STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT</b>	
1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the last 180 days? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #2)	
2. Is there a documented allergy or contraindication to preferred agents in this class? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #3)	
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Deny)	



**STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA**

1. Is the client greater than or equal to ( $\geq$ ) 18 years of age?

Yes (Go to # 2)

No (Deny)

2. Does the client have a diagnosis of post-herpetic neuralgia or neuropathy in the last 730 days?

Yes (Go to #3)

No (Deny)

3. Is the client currently taking a contraindicated drug?

Examples of contraindicated drugs include amiodarone (CORDARONE, PACERONE), disopyramide (NORPACE), flecainide, mexiletine, propafenone (RYTHMOL), quinidine, sotalol (BETAPACE), TIKOSYN, and others.

Yes (Deny)

No (Go to #4)

4. Does the request exceed the maximum recommended daily dose (3 patches per day)?

Yes (Deny)

No (Approve – 365 days)

**STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If criteria not met, submit chart documentation with form citing complex medical circumstances.  
For questions, please call Navitus Customer Care at 1-877-908-6023.