univera HEALTHCARE

Lidocaine Patch &
Diclofenac Epolamine Patch
Medicare-D

Drug Evaluation Request Form

Complete this form and fax to:
Fax #: 1-800-956-2397
Urgent Request Only Fax: 1-800-208-4050

For Assistance Completing this form:
Pharmacy Help Desk Fax: 1-800-956-2397
Phone: 1-800-499-1275

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Select one Medication/Medical and Provide Dispensing Information

Medication (HCPCS)	Dose	Frequency	Weight (lbs. or kg)	Procedure Code
☐ **Lidocaine Patch**				
☐ **Diclofenac epolamine patch**				

Diagnosis/ICD-10:

Is this request for a: ☐ New Start ***OR*** ☐ Continuation of Therapy (Recertification) Start date: _____

The definition of a **medically-accepted indication** is listed in Chapter 6 (Part D Drugs and Formulary Requirements) Section 10.6 of the Medicare Prescription Drug Benefit Manual: "Section 1860D-2(e)(1)(B) of the Act limits "medically-accepted indication," by reference to section 1927(k)(6) of the Act, to any use of a covered Part D drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Act. The compendia are 1. American Hospital Formulary Service Drug Information, 2. DRUGDEX Information System, and 3. United States Pharmacopeia-Drug Information (or its successor publications).

Questions/Indications for Medical Necessity

For lidocaine patch requests: What is your patient's diagnosis?

- ☐ Post-herpetic neuralgia (PHN)?
- ☐ Diabetic peripheral neuropathy?
- ☐ Other: _____

For Diclofenac epolamine patch requests: What is your patient's diagnosis?

- ☐ Acute pain (less than 3 months) due to minor strains, sprains, and contusions
- ☐ Other: _____

Provide Other Comments/Clinical Justification:

*Prescriber Signature: _____ Date: _____

I certify the above information is true and accurate to the best of my knowledge.