

Local Anesthetics - Topical
Phone: 215-991-4300
Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:		Prescriber Name:	
HPP Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Primary Phone:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for lidocaine viscous oral solution or lidocaine oral jelly?

 Yes

 No

Q2. Is the patient 3 years of age or older?

[Note: Prior Authorization for lidocaine viscous oral solution or lidocaine oral jelly is only required for patients less than 3 years of age.]

 Yes

 No

Q3. Is the requested drug being prescribed for the treatment of teething pain?

 Yes

 No

Q4. Does the patient have documented therapeutic failure, contraindication to, or intolerance of alternative recommended treatments for the patient's indication?

 Yes

 No

Q5. Is the patient prescribed a dose that is consistent with United States Food and Drug Administration (US FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Does the patient have a documented history of therapeutic failure, intolerance of, or contraindication to the preferred topical local anesthetic drugs?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Additional Information:	

Prescriber Signature_____
Date

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