



**BlueCross  
BlueShield**

Federal Employee Program

**LIDOCAINE TOPICALS  
PRIOR APPROVAL REQUEST**

Send completed form to:  
Service Benefit Plan  
Prior Approval  
P.O. Box 52080 MC 139  
Phoenix, AZ 85072-2080  
Attn: Clinical Services  
Fax: **1-877-378-4727**

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

| Patient Information (required)            |  |  |      | Provider Information (required) |  |             |
|---|--|--|------|---------------------------------|--|-------------|
| Date:                                     |  |  |      | Provider Name:                  |  |             |
| Patient Name:                             |  |  |      | Specialty:                      |  | NPI:        |
| Date of Birth:                            |  | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |      | Office Phone:                   |  | Office Fax: |
| Street Address:                           |  |  |      | Office Street Address:          |  |             |
| City:                                     |  | State:   | Zip: | City:                           |  | State: Zip: |
| Patient ID: <b>R</b> <input type="text"/> |  |  |      | Physician Signature:            |  |             |
| <b>PHYSICIAN COMPLETES</b>                |  |  |      |                                 |  |             |

**Lidocaine Topicals**

**NOTE:** Form must be completed in its **entirety** for processing

**Please select medication:**

☐ Emla (lidocaine 2.5% and prilocaine 2.5%)

☐ Tetravex gel (tetracaine 2%)

☐ Lidocaine ointment 5%

\*Check [www.fepblue.org/formulary](http://www.fepblue.org/formulary) to confirm which medication is part of the patient's benefit

Is this request for brand or generic? ☐ Brand ☐ Generic

How many grams are required for 90 days? \_\_\_\_\_ gram(s) per 90 days

1. What is the patient's diagnosis?

☐ Local analgesia

☐ Local wound pain

☐ Other diagnosis (*please specify*): \_\_\_\_\_

2. Is the requested medication being used for pain associated with a cosmetic procedure? ☐ Yes ☐ No

3. **Emla Request:** Is the patient currently on dialysis? ☐ Yes ☐ No