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: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

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 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