

**NC Division of Medical Assistance
Outpatient Pharmacy
Prior Approval Criteria
Topical Local Anesthetics**

Medicaid and Health Choice

Revised Date: 06/15/2012

Therapeutic Class Code: Q5H

Therapeutic Class Description: Topical Local Anesthetics

Medication	Generic Code Number(s)	NDC Number(s)
Lidoderm 5% Patch	50272	

Eligible Beneficiaries

NC Medicaid (Medicaid) beneficiaries shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NCHC) beneficiaries, ages 6 through 18 years of age, shall be enrolled on the date of service to be eligible, and must meet policy coverage criteria, unless otherwise specified. **EPSDT does not apply to NCHC beneficiaries.**

EPSDT Special Provision: Exception to Policy Limitations for Beneficiaries under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. Additional information on EPSDT guidelines may be accessed at <http://www.ncdhhs.gov/dma/epsdt/>.

Criteria:

- Patient diagnosed with Post-Herpetic Neuralgia.
OR
- Neuropathic pain with a previous documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressants, SSRI's, SNRI's, anticonvulsants, NSAID's or COXII's
OR
- Chronic musculo-skeletal pain (greater than 6 month in duration) with a previous documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressants, SSRI's, SNRI's, anticonvulsants, NSAID's or COXII's
AND
- Prescribed dose within the FDA recommended maximum amount of 3 patches per day and no more than 90 patches per month.

Procedures:

- New prescriptions will be limited to coverage of 1 box (30 patches) upon the first fill. Subsequent refills will be for up to a 34 day supply.
- Length of therapy may be approved for up to 12 months.

References

1. Local Anesthetics, Topical. Drug Facts and Comparisons, Drug Facts and Comparisons, Wolters Kluwer Health. St. Louis (MO): updated monthly.
2. Prescriber Information-Lidoderm Patch ® (lidocaine patch 5%), Endo Pharmaceuticals, Inc., Chadds Ford, Pennsylvania 19317. March 2010.
3. Gold Standard, Inc. Lidoderm. *Clinical Pharmacology* [database online]. Available at: <http://www.clinicalpharmacology.com>. Accessed April 12, 2011.
4. Jefferies, K. Treatment of Neuropathic Pain. *Semin Neurol*. 2010; 30(4):425-432. <http://www.medscape.com/viewarticle/730671> Accessed April 12, 2011.
5. Attal, N et al. EFNS guidelines on the pharmacological treatment of neuropathic pain: 2010 revision. *European Journal of Neurology* 2010; 17: 1113-1123.
6. Dworkin, RH et al. Pharmacologic management of neuropathic pain: evidence-based recommendations. *Pain* 2007 Dec 5; 132 (3):237-51.
7. Argoff, Charles E. et al. Consensus Guidelines: Assessment, Diagnosis, and Treatment of Diabetic Peripheral Neuropathic Pain. *Mayo Clinic Proceedings* April 2006; 81 (4 suppl): S1-S25.