Prior Authorization Request Form for Iofexidine (Lucemyra)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is Lucemyra being prescribed for mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation?	☐ Yes **Proceed to Question 2**	☐ No **STOP** **Coverage not approved**
2. Is the patient 18 years of age or older?	☐ Yes **Proceed to Question 3**	☐ No **STOP** **Coverage not approved**
3. Will Lucemyra be prescribed for longer than 14 days?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to Question 4**
4. Please explain why the patient cannot use the preferred product clonidine.	**Sign and date below**	

Prior Authorization Request Form for lofexidine (Lucemyra)

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[28 November 2018]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered:

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	Name:
Date Faxed to MD:	Date Decision Rendered: