Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Lucemyra (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Lucemyra (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Lucemyra (lofexidine)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Does the member have symptoms of opioid withdrawal due to abrupt opioid discontinuation? Y N

   [If no, then no further questions.]

2. Has the member had a trial and failure, or contraindication to clonidine or has a clinically significant adverse effect? Y N

   [If no, then no further questions.]

3. Is the member on a behavioral modification plan for substance abuse counseling (psychosocial support)? Y N

[If no, then no further questions.]

4. Has a recent urine drug screen been performed verifying the member is not currently taking benzodiazepines, alcohol, barbiturates, or other sedating drugs? Y N

   [If no, then no further questions.]

5. Does the provider attest that the member does not have congenital long QT syndrome, and the provider has monitored the member's vital signs prior to dosing? Y N

   [If no, then no further questions.]

6. Does the provider attest that the member is not on concurrent strong CYP2D6 inhibitors such as paroxetine, fluoxetine, bupropion, quinidine, or cinacalcet? Y N

   [If no, then no further questions.]

7. Does the provider attest that the member does not have severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, chronic renal failure, or marked bradycardia? Y N

   [If no, then no further questions.]

8. Is the member 18 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**