Updated: 05/2021
DMMA Approved: 05/2021

Request for Prior Authorization for Lucemyra (lofexidine)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Lucemyra (lofexidine) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Lucemyra (lofexidine) Prior Authorization Criteria:

For all requests for Lucemyra (lofexidine) all of the following criteria must be met:

- The member is 18 years of age or older
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided for the mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation and the following criteria is met:

- Documentation of the following:
  - Self-reported opioid use ≥ 21 of the last 30 days
  - Score of ≥ 2 on the Handelsman Objective Opiate Withdrawal Scale [OOWS-Handelsman]
  - Provider attestation of a hypotensive episode requiring a change in therapy while on clonidine therapy
- **Duration of Approval:** 14 Days

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

Table 1. Handelsman Objective Opiate Withdrawal Scale

Score	Description
	Yawning (one or more during observations)
	Rhinorrhoea (greater than three sniffs during observation)
	Piloerection (gooseflesh – observe patient's arm)
	Lacrimation
	Mydriasis (dilated pupils)
	Tremors (hands)
	Hot and cold flushes (shivering or huddling for warmth)
	Restlessness (frequent shifts in position)
	Vomiting
	Muscle twitches
	Abdominal cramps (holding stomach)
	Mild anxiety (scores one) – fidgeting, foot-shaking, finger-tapping Moderate (scores two) to severe anxiety (scores three) – agitation, unable to sit, trembling, panicky, difficulty in breathing, choking sensations, palpitations
	Total Score (maximum 14)

Scoring: Absent = 0, Present = 1

HIGHMARK. Delaware HEALTH OPTIONS

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LUCEMYRA (lofexidine) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

What is the member's self-reported opioid use within the last 30 days? _____ days of the past 30 days
What is the member's score on the Handelsman Objective Opiate Withdrawal Scale [OOWS-Handelsman]? _____
Did the member have a hypotensive episode while on clonidine therapy? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date