Gateway Health
Prior Authorization Criteria
Lucemyra (lofexidine)

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:

Members with historical pharmacy claims data meeting the following criteria will receive automatic authorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the criteria. Claims will automatically adjudicate on-line, without a requirement to submit for prior authorization when the following criteria is met:

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

- Member has tried and failed or had an intolerance to clonidine in the past 90 days
- **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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

Updated: 09/2018
PARP Approved: 09/2018

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 Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Gateway 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:

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)

Diagnosis:_____ ICD-10 Code: _____

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date