OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

Drug Requested: Lucemyra™ (lofexidine)

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Informational: 1 treatment course every 6 months

CLINICAL CRITERIA: To receive approval for this drug, all information below **must** be checked to qualify or authorization process will be delayed.

Initial Approval – Three (3) day initial approval.

1. Used for mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation? ❑ Yes ❑ No

AND

2. Is the member 18 years or older? ❑ Yes ❑ No

AND

3. The is **NOT** pregnant or breastfeeding? ❑ Yes ❑ No

AND

4. The member does **NOT** have a prolonged QT interval (> 450 msec for males, 470 msec for females? ❑ Yes ❑ No

AND

5. The prescriber to provide verbal attestation that if member is currently taking methadone, baseline electrocardiogram (ECG) has been performed? ❑ Yes ❑ No

AND

6. Member has tried and failed, had a contraindication to, or experienced an adverse reaction/intolerance to buprenorphine and methadone? ❑ Yes ❑ No

AND

7. Member has tried and failed, had a contraindication to, or experienced an adverse reaction/intolerance to clonidine? ❑ Yes ❑ No

AND

(continued on next page)

8. Prescriber to provide verbal attestation of a comprehensive treatment plan between provider and member? ❑ Yes ❑ No

AND

9. In the case of opioid use disorder (OUD), provide verbal attestation that member: ❑ Yes ❑ No

- Has a referral to OR active involvement in substance abuse counseling; **OR**
- Is unable to have counseling AND provides verbal attestation that member has been offered medication-assisted treatment (MAT) as part of a comprehensive treatment plan?

AND

10. Provide verbal attestation that member is **NOT** prescribed concurrent opioid medication without explanation (verified by Prescription Monitoring Program (PMP))? ❑ Yes ❑ No

AND

11. Provide verbal attestation that member is capable of and instructed how to self-monitor for hypotension, orthostasis, bradycardia, and associated symptoms? ❑ Yes ❑ No

AND

12. Provide verbal attestation that member has been provided with a tapering schedule and instructions on when to contact their healthcare provider for further guidance? ❑ Yes ❑ No

RENEWAL APPROVAL

1. Continue to meet criteria above? ❑ Yes ❑ No

AND

2. If the renewal is a continuation of the initial approval because additional therapy is needed, approve up to 4 additional days (for a total of 7 days of treatment). ❑ Yes ❑ No

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED: 10/27/2018**