

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Lucemyra - Medicare Core & DSNP only (2025)

Phone: 215-991-4300 Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.			
Member Name:		Prescriber Name:	
Member Number:		Fax: Phone:	
Date of Birth:		Office Contact:	
Line of Business:	□ Medicare Advantage	NPI: State Lic ID:	
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Primary Phone:		Specialty/facility name (if applicable):	
	DITED REVIEW: By checking this box and signing below, I on the enrollee's ability to regain maximum functions.	certify that applying the 72 hour standard review timeframe may seriously jeopardize on.	
Drug Name:			
Strength:			
Directions / SIG:			
Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.			
Q1. Is the patient 18 years of age or older?			
☐ Yes		□ No	
Q2. Does the patient have a diagnosis of acute opioid withdrawal documented by an opioid withdrawal scale (such as Objective Opioid Withdrawal Scale [OOWS], Clinical Opioid Withdrawal Scale [COWS], Subjective Opioid Withdrawal Scale [SOWS])? Chart notes must be attached.			
☐ Yes		□ No	
Q3. Does the patient have documentation of an inadequate response, inability to tolerate, or contraindication to clonidine?			
☐ Yes		□ No	
Q4. Is the req	uest for brand Lucemyra?		
☐ Yes		□ No	
Q5. Is there documentation of inadequate response, intolerance, or contraindication to generic lofexidine?			

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Member Name:	Prescriber Name:	
□Yes	□ No	
Q6. Requested Duration:		
☐ 14 Days	☐ Other:	
Q7. Additional Information:		
Prescriber Signature	Date	
	v2025	

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