COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

DUR MEDICATION LUCEMYRA® (lofexidine)

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

 Revised: 10/28/2022 | Effective: 07/22/2021

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

LUCEMYRA® – to receive approval for this drug, complete the following questions.

Initial Approval: Three (3)-day initial approval

1. Is the medication used for the mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation? **AND**

   ☐ Yes ☐ No

2. Is the member 18 years or older? **AND**

   ☐ Yes ☐ No

3. Is the member **NOT** pregnant or breastfeeding? **AND**

   ☐ Yes ☐ No

4. Does the member **NOT** have a prolonged QT interval (> 450 msec for males, > 470 msec for females)? **AND**

   ☐ Yes ☐ No

5. Will the prescriber provide verbal attestation that, if member is currently taking methadone, a baseline electrocardiogram (ECG) has been performed? **AND**

   ☐ Yes ☐ No

6. Has the member tried and failed, had a contraindication to, or experienced an adverse reaction/intolerance to buprenorphine and methadone? **AND**

   ☐ Yes ☐ No

7. Will the prescriber provide a verbal attestation of a comprehensive treatment plan between provider and member? **AND**

   ☐ Yes ☐ No

8. In the case of opioid use disorder (OUD), can verbal attestation be provided that the member:

   - 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**

   ☐ Yes ☐ No

9. Has verbal attestation been provided that the member has **NOT** been prescribed concurrent opioid medication without explanation (verified by Prescription Monitoring Program [PMP])? **AND**

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

10. Will verbal attestation be provided that the member is capable of and instructed how to self-monitor for hypotension, orthostasis, bradycardia, and associated symptoms? **AND**

☐ Yes ☐ No

11. Will verbal attestation be provided that the member has been provided with a tapering schedule and instructions on when to contact their healthcare provider for further guidance?

☐ Yes ☐ No

Renewal Approval:

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).

12. Does the member continue to meet criteria above?

☐ Yes ☐ No

Informational:

Limit 1 treatment course every 6 months

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Magellan Medicaid Administration / ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060