LUCEMYRA PRIOR AUTHORIZATION REQUEST FORM

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Optum Rx®

United Healthcare Community Plan

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Quantity	Dosage Regimen	Treatment Duration

***Note: Requested dose may not exceed 16 tablets (2.88 mg) per day; duration may not exceed 14 days, for 1 treatment course every 180 days**

PA requirements for LUCEMYRA (LOFEXIDINE)

1. Previous trial and failure of a guideline-accepted alpha-2 adrenergic agonist agent ☐ Yes ☐ No

   If yes, name of previous alpha-2 adrenergic agonist agent(s) and dose(s) trialed: _____

   _____

   Note: confirmation of previous trial by claims history or submitted chart documentation is required

   If no, please provide medical justification for use over other alpha-2 adrenergic agonist agents:

   _____

   _____

   _____

2. Requested quantity does not exceed 16 tablets (2.88 mg) per day ☐ Yes ☐ No

3. Requested claim is within the **plan limitation maximum** of 7-day supply with a subsequent claim(s) not to exceed 7-day supply (for a total of 14 days of therapy) every 180 days? ☐ Yes ☐ No

   If no, please provide medical rationale for continued use beyond 14 days:

   _____

   _____

   _____