CareSource Rx Innovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
LUCEMYRA PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date ☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

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

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

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐ / ☐☐ / ☐☐☐☐
Prescriber's Address	Date(s) of Service: _____ Start Date: _____
Diagnosis	Diagnosis Code

Requested Medication	Quantity	Directions for Use	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.**

I attest that the provided information above is accurate:

Physician Signature: _____ **Date:** _____

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:

   _____

   _____

   _____