Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Lofexidine (Lucemyra) – Medical Necessity Request

Please complete page 1 for New/Initial Requests

1. Does the member have a diagnosis of opioid use disorder? **Yes or No**

   □ If No, what is the diagnosis?
   _____

2. Is the member currently undergoing or scheduled to undergo abrupt opioid discontinuation? **Yes or No**

3. Is the medication being prescribed by or in consultation with a provider specializing in pain management or addiction treatment? **Yes or No**

4. Does the member have a history of congenital long QT syndrome? **Yes or No**

   □ If Yes, will the medication be used with caution? **Yes or No**

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**.