Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Lucemyra

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 greater than or equal to 18
☐ Yes ☐ No

Q2. Is the medication being prescribed by, or in consultation with, a pain management or addiction specialist?
☐ Yes ☐ No

Q3. Will the patient be treated with concurrent opioids?
☐ Yes ☐ No

Q4. Does the patient have a diagnosis of acute opioid withdrawal documented by a validated 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

Q5. Is there documentation that the patient has a treatment plan in place to abruptly discontinue the use of an opioid? Treatment plan must be attached.
☐ Yes ☐ No

Q6. Is there documentation showing that the patient has tried and failed or has a contraindication to formulary alternatives (such as clonidine)? Pharmacy or clinical chart notes must be attached.
☐ Yes ☐ No

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Q7. Is there documentation of an appropriate treatment plan that does not exceed 14 days of therapy and a plan to gradually decrease Lucemyra over a 2-4 day period? Taper plan including total daily dose prescribed must be attached.

☐ Yes ☐ No

Q8. Is there documentation that the patient has been educated on self-monitoring for signs and symptoms of bradycardia and orthostasis? Documentation that the patient has been counseled must be attached.

☐ Yes ☐ No

Q9. Is there documentation that the patient has been counseled on the risks of abruptly discontinuing Lucemyra (such as rise in blood pressure, diarrhea, insomnia, anxiety hyperhidrosis and extremity pain)? Documentation that the patient has been counseled must be attached.

☐ Yes ☐ No

Q10. Is there documentation that the patient has been counseled on the increased risk of Opioid Overdose if they resume treatment with opioids? Documentation that the patient has been counseled must be attached.

☐ Yes ☐ No

Q11. Does the patient have severe coronary insufficiency, recent myocardial infarction (MI), or marked bradycardia? Documentation must be attached

☐ Yes ☐ No

Q12. Does the patient have congenital QT syndrome or arrhythmias associated with a prolonged QT interval or currently taking a drug known to prolong the QT interval (such as chlorpromazine, haloperidol, thioridazine, ziprasidone, moxifloxacin, Class 1A antiarrhythmic medications [quinidine, procainamide] and Class III antiarrhythmic medications [amiodarone, sotalol])? (Please attach documentation showing that the patient has been evaluated for cardiac abnormalities).

☐ Yes ☐ No

Q13. Requested Duration:

☐ 14 days

Q14. Additional Information

Prescriber Signature _____ Date _____

Updated 2018