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. Is the medication being used for symptoms of opioid withdrawal due to abrupt opioid discontinuation? **Yes or No**

2. Is the medication being used as part of a comprehensive management program for the treatment of opioid use disorder? **Yes or No**

3. Is the request for more than 14 days of therapy? **Yes** or **No**
   □ . If Yes, what is the clinical reason for requesting more than 14 days of therapy?
   _____

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