266 N 4th St, Suite 200
Columbus, OH 43215
Phone: 1(833) 614-4438
NPI: 1932780475
NCPDP: 3688833

giftheath

Please **FAX** patient demographics with prescription order form to:

Toll-Free Fax 1-833-427-1165

Lucemyra®

Patient Information:

Name: _____ Date of Birth: _____

Patient's Home Address: _____

City: _____ State: _____ Zip: _____

Patient's Mailing Address (if different from home): _____

Phone: _____ Alt. Phone: _____ SS#: _____

Gender: M or F Drug Allergies: _____

PLEASE INCLUDE: ☐ ***Demographics*** ☐ ***Medication List*** ☐ ***Prescription Insurance***

Clinical Information:

Diagnosis (ICD-10): _____ F11.23 Opioid Dependence w/ Withdrawal

_____ Other

Has the patient, or will the patient, abruptly discontinue opioid use prior to starting Lucemyra?

Has the patient tried/failed, does patient have a contraindication to, or has patient experienced an adverse reaction/intolerance to any/all of the following medications (tried/failed REQUIRED for Lucemyra approval): Yes or No

*****Check all that apply** PLEASE ALSO NOTE: Some insurance plans will request detailed office notes on tried/failed medications***

☐ Clonidine ☐ Buprenorphine ☐ Methadone

Trial Dates _____

Is the patient pregnant or nursing? Yes or No

☐ Lucemyra® 0.18mg tablets **Qty:** 96 tablets **Sig:** Take 1-4 tablets by mouth 4 times daily, as guided by symptoms, not to exceed 16 tablets per day.

☐ Lucemyra® 0.18mg tablets **Qty:** 192 tablets **Sig:** Take 1-4 tablets by mouth 4 times daily as guided by symptoms **Refills:** _____

Prescriber Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

NPI: _____ DEA: _____

Office Contact: _____ Direct Line: _____

Preferred Pharmacy: _____

By signing this form and utilizing our services, you are authorizing Gifthealth and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Patient assistance programs. My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate and therapy identified is medically necessary.

Prescriber Signature: _____ Date: _____