ST. MATTHEWS
Community Pharmacy
A CORDANT HEALTH SOLUTIONS® COMPANY

Fax: 502-690-4466 | Phone: 502-690-4462

OPIOID DETOX FORM

Need By Date:____/____/____ SHIP TO: ☐ Office ☐ Patient ☐ Patient pick up in pharmacy

PATIENT INFO

Name:_____

Address:_____

City:_____ State:____ ZIP:_____

Phone:_____ Alt Phone:_____

SSN:_____ DOB:_____

Height:_____ Weight:_____

Alt. Contact:_____ Phone:_____

PROVIDER INFO

Name: _____

Address: _____

City:_____ State:____ ZIP:_____

Phone:_____ Alt Phone:_____

NPI:_____ DEA:_____

License #:_____

Contact Person:_____ Sp#:_____

PLEASE FAX A COPY OF THE PATIENT'S PRESCRIPTION CARD AND MEDICAL CARD FRONT AND BACK

Diagnosis/Clinical Information | Please FAX recent clinical notes, labs and tests with the prescription to expedite the prior authorization

Select Diagnosis Code (ICD-10):

☐ F11.23 Opioid Dependence w/ Withdrawal ☐ F11.93 Opioid Use; Unspecified, w/Withdrawal

☐ Other:_____

Has the patient, or will the patient, abruptly discontinue opioid use prior to starting Lucemyra? ☐ Yes ☐ No

Has the patient been offered patient counseling and psychosocial support in addition to Lucemyra therapy? ☐ Yes ☐ No

Has the patient tried and failed, has a contraindication to, or experienced an adverse reaction/tolerance to clonidine, Suboxone, and/or methadone? ☐ Yes ☐ No

Is the patient at risk for QT prolongation (CHF, arrhythmia, hepatic impairment, renal impairment, or taking other medicine products that contribute to QT prolongation)? ☐ Yes ☐ No

List any other prior failed treatments for this diagnosis:_____

List patient medication allergies:_____

PRESCRIPTION INFORMATION

Medication	Dosage & Strength	Directions	Qty	Refills
☐ LUCEMYRA	0.18mg tablet	Take 3 tablets by mouth four times a day for 7 days, then 2 tablets by mouth four times a day for 1 day, then 1 tablet by mouth four times a day for 1 day	☐ 96 ☐ 192	___
☐ LUCEMYRA	0.18mg tablet	Take 1–4 tablets by mouth 4 times daily	☐ 96 ☐ 192	___

Prescriber Authorization: I hereby authorize St. Matthews Specialty Pharmacy to complete and submit prior authorization ("PA") requests to payors for the prescribed medication for this patient, to attach supporting documentation provided by my office, and to attach this form to the PA request as my signature.

Prescriber's Signature:_____ **Date:**____/____/____

Patient Authorization: I authorize St. Matthews Specialty Pharmacy to bill my insurance company for this prescription and refills of this prescription. I understand that I am financially responsible for any co-pay / co-insurance amounts or other amounts not covered by my insurance. I understand that either I or my authorized representative will need to contact St. Matthews Specialty Pharmacy if there are changes in my insurance or I no longer need this prescription.

I authorize St. Matthews Specialty Pharmacy to disclose protected health information to third parties, including insurance carriers, pharmacy benefit managers, pharmaceutical manufacturers, or their agents, as necessary to secure PA for the prescribed medication.

I allow my prescriber to be my authorized individual and may order my prescription refills / schedule delivery or pickup of my prescription.

I understand I have an offer for prescription counseling by the pharmacist and may contact the pharmacy for such counseling in the future but decline the offer of counseling at this time.

Patient's Signature:_____ **Date:**____/____/____

Revised 9/9/21