TFP WELLNESS SYSTEMS
Your Lifetime Pharmacy Solution

Lucemyra Enrollment Form

Phone: (813) 871-5161 ext. 34993
Fax: (813) 877-2479

PATIENT INFORMTION (OR ATTACH PATIENT DEMOGRAPHIC SHEET)				
Patient Name:	☐Male ☐Female	Allergies: ☐NKDA		
Date of Birth:	SSN:	Weight: ☐kg ☐lb	Date:	
Address:	City:	State:	Zip:	
Phone # (Home):	Work #:	Email (Optional):		

INSURANCE INFORMATION (PLEASE PROVIDE COPIES OF MEDICAL AND PRESCRIPTION CARDS, IF AVAILABLE)		
Primary Insurance:	RX Bin:	RX PCN:
RX Group:	RX ID:	RX Phone:
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder's SSN:

DIAGNOSIS/MEDICAL INFORMATION

Diagnosis: ☐ F11.23 Opioid Dependence w. Withdrawal ☐ F11.93 Opioid Use, Unspecified, w/ Withdrawal
☐ Other ICD-10:

Clinical Questions:

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 psychological support in addition to Lucemyra therapy? ☐Yes ☐No

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

If **Yes**, which medications and dates: _____

If the patient is at risk for QT prolongation (CHF, Bradyarrhythmia, Hepatic Impairment, Renal Impairment, or taking other medicinal products that lead to QT prolongation), has an ECG been performed? ☐Yes ☐No

Attachments: MARS included? ☐Yes ☐No Chart notes included? ☐Yes ☐No

PRESCRIPTION INFORMATION

MEDICATION	DOSE	QTY	DIRECTIONS	REFILLS
☐ Lucemyra®	☐ 0.18 mg tablets	**96**	Take 3 tablets by mouth 4 times daily on days 1-7, 2 tablets by mouth 4 times daily on day 8, 1 tablet by mouth 4 times daily on day 9, then discontinue.	**N/A**
☐ Lucemyra®	☐ 0.18 mg tablets	☐ **96** ☐ **192**	Take 1-4 tablets by mouth 4 times daily, as guided by symptoms, not to exceed 16 tablets per day.	

DELIVERY INSTRUCTIONS

☐ Physician Office ☐ Rehabilitation Facility ☐ Patient's Home
☐ 1st dose to Rehabilitation Facility, Refills to patient's home ☐ 1st dose to MD office, Refills to patient's home

PHYSICIANS CONTACT INFORMATION & AUTHORIZATION		
Physician's Name:	Office Contact:	Institution:
Phone #:	Fax #:	Specialty:
Address:	City/State/Zip:	
Tax ID:	DEA #:	NPI #:
Physician's Signature:		Date:

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original document. Created: 09/24/2021