

**Request for Prior Authorization
 DEXTROMETHORPHAN and QUINIDINE
 (NUEDEXTA)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID # _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	Patient name	DOB
Patient address		
Provider NPI _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	Pharmacy fax	NDC _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Prior authorization is required for Nuedexta™. Payment will be considered under the following conditions: 1) Patients must have a diagnosis of pseudobulbar affect (PBA) secondary to a neurologic condition. 2) A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI; and 3) Patient has documentation of a current EKG (within the past 3 months) without QT prolongation. 4) Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Liability Scale (CNS-LS) questionnaire. 5) Subsequent prior authorizations will be considered at 6 month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

Nuedexta™

Strength Dosage Instructions Quantity Days Supply

Diagnosis: _____

Treatment failure with amitriptyline or an SSRI:

Trial Drug Name & Strength: _____ Trial start date: _____ Trial end date: _____

Reason for failure: _____

Initial CNS-LS Questionnaire Score: _____ **Date of Completion:** _____

Subsequent CNS-LS Questionnaire Score: _____ **Date of Completion:** _____

Does recent EKG indicate QT prolongation: Yes No **Date of Completion:** _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.