iowa total care | ia health link | Hawki

Request for Prior Authorization
DEXTROMETHORPHAN and QUINIDINE (NUEDEXTA)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

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 Lability 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

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.*