Pharmacy Prior Authorization

MERCY CARE - GMHSA (MEDICAID)

Nuedexta (AZ88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Mercy Care – GMHSA at **1-855-246-7736**.
When conditions are met, we will authorize the coverage of Nuedexta (AZ88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name ***(circle drug)***

Nuedexta (dextromethorphan/quinidine)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis:_____ **ICD Code:**_____

Circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Has the member had a decrease in pseudobulbar affect (PBA) episodes? Y N

   [No further questions]

3. Does the member have a diagnosis of pseudobulbar affect (PBA)? Y N

   [If no, then no further questions.]

4. Does the member have at least ONE underlying neurologic condition associated with PBA? Y N

   [If no, then no further questions.]

5. Has the member had a cognitive assessment to evaluate for the presence of pseudobulbar affect (PBA) (for example, Center for Neurologic Study-Lability Scale (CNS-LS) greater than or equal to 13, The Pathological Laughter and Crying Scale (PLACS) greater than or equal to 13)? Y N

   [If no, then no further questions.]

6. Does the member have any contraindication to therapy (for example, QT prolongation, atrioventricular (AV) block, or currently on monoamine oxidase inhibitor (MAOI) therapy)? Y N

   [If yes, then no further questions.]

7. Is the member 18 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**