Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Nuedexta - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Does the patient have a confirmed diagnosis of pseudobulbar affect (PBA)?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Is the requested drug being prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q4. Does the patient have any of the following: A) history of quinidine, quinine, or mefloquine-induced thrombocytopenia, hepatitis, or other hypersensitivity reactions, B) known hypersensitivity to dextromethorphan, C) prolonged QT interval, congenital long QT syndrome, history suggestive of torsades de pointes, or heart failure, D) complete atrioventricular (AV) block without implanted pacemaker, or at high risk of complete AV block?

☐ Yes ☐ No

Q5. Will the requested drug be used concomitantly with any of the following: A) quinidine, B) quinine, C) mefloquine, D) drugs that both prolong the QT interval and are metabolized by CYP2D6 (e.g. thioridazine or pimozide)?

☐ Yes ☐ No

Q6. Will the requested drug be used with a monoamine oxidase inhibitor (MAOI) or within 14 days of stopping a MAOI?

☐ Yes ☐ No

Q7. Is the patient at risk of QT prolongation and torsades de pointes? [Note: patients at risk of QT prolongation and

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torsades de pointes include recipients concomitantly taking any CYP3A4 inhibitors or medications which may prolong the QT interval and recipients with left ventricular hypertrophy or left ventricular dysfunction.]

☐ Yes ☐ No

Q8. Will the patient have a baseline EKG and an EKG evaluation 3 to 4 hours after the first dose?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 Months

Q10. Additional Information:

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request