OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name*** ***(preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Nuedexta®** (dextromethorphan hydrobromide and quinidine sulfate)

DRUG INFORMATION: ***Complete information below. If incomplete, authorization process will be delayed.***

Drug Form/Strength: ____________________

Dosing Schedule: ____________________ **Length of Therapy**: ____________________

Diagnosis: ____________________ ***ICD Code, if applicable***: ____________________

Limited dosing: ***2 capsules per day***

CLINICAL CRITERIA: ***ALL the boxes below MUST be checked to qualify or authorization process will be delayed. .***

- ❑ Patient has a diagnosis of pseudobulbar affect (PBA) associated with ***(check one):***
  - ❑ Multiple Sclerosis
  - ❑ Amyotrophic Lateral Sclerosis (ALS)
  - ❑ Stroke
  - ❑ Traumatic Brain Injury

AND

- ❑ Patient does not have a depression diagnosis or depression is currently managed

AND

- ❑ Patient is at least 18 years of age

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: ____________________

Member Optima #: ____________________ Date of Birth: ____________________

Prescriber Name: ____________________

Prescriber Signature: ____________________ Date: ____________________

Office Contact Name: ____________________

Phone Number: ____________________ Fax Number: ____________________

DEA OR NPI #: ____________________

***REVISED/UPDATED: 7/1/2018**