OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 or 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 to ensure authorization will **NOT** 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:** ~~8/26/2017;~~ **8/27/2018**