OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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: 8/26/2017**