

# OPTIMA HEALTH PLAN

## 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 #: \_\_\_\_\_

\*Approved by Pharmacy and Therapeutics Committee: 5/19/2011

REVISED/UPDATED: 9/13/2011; 4/10/2014; 11/6/2014; 5/22/2015; 7/16/2015; 8/11/2015; 12/28/2015; 12/19/2016; 9/22/2017