https://providers.amerigroup.com

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Nuedexta (dextromethorphan and quinidine) Prior Authorization of Benefits (PAB) Form Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION

Patient Name: _____
Patient ID #: _____
Patient DOB: _____
Date of Rx: _____
Patient Phone #: _____
Patient Email Address: _____

2. PHYSICIAN INFORMATION

Prescribing Physician: _____
Physician Address: _____
Physician Phone #: _____
Physician Fax #: _____
Physician Specialty: _____
Physician DEA: _____
Physician NPI #: _____
Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Nuedexta (dextromethorphan and quinidine)	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

☐ Yes ☐ No Patient has a diagnosis of pseudobulbar affect (PBA) secondary to a neurological condition

☐ Yes ☐ No Patient has had a trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI (Viibry, Brintellix, celexa, citalopram hydrobromide, escitalopram oxalate, Lexapro, fluoxetine hcl, fluoxetine hcl caps 40mg, fluoxetine hcl capsule delayed release, fluoxetine hcl tabs 20mg, Prozac, Prozac Weekly, fluvoxamine maleate, paroxetine hcl, paroxetine hcl er, Paxil, Paxil CR, Paxil Susp, Pexeva, Sarafem, Brisdelle)

☐ Yes ☐ No Documentation* has been provided with this request showing evidence that the use of the above medications would be medically contraindicated

☐ Yes ☐ No Documentation* has been provided with this request of a current EKG (within the past 3 months) without QT prolongation

☐ Yes ☐ No Request is for initial therapy

- ☐ Yes ☐ No A baseline Center for Neurologic Studies Liability Scale (CNS-LS) questionnaire has been provided with this request

☐ Yes ☐ No Request is for continuation of therapy

- ☐ Yes ☐ No Documentation* has been provided with this request showing efficacy as seen in an improvement in the CNS-LS questionnaire

***Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.**

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PATIENT NAME: _____ **PATIENT ID #:** _____

9. PHYSICIAN SIGNATURE

_____ _____ Prescriber or Authorized Signature Date
Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.
The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.