

# Nuedexta

## Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-396-4139

FAX 412-454-7722

### PLEASE TYPE OR PRINT NEATLY

*Incomplete responses may delay this request.*

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:	Provider Fax:	Provider NPI #:	

Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:

*Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.*

<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate place of administration? <input type="checkbox"/> Physician Office <input type="checkbox"/> Hospital/Facility	Please indicate how medication will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient		
Please provide facility/provider name and address:			

### MEDICAL HISTORY

Does the member have a diagnosis of pseudobulbar affect (PBA)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please specify the members under-lying diagnosis:	

- Amyotrophic Lateral Sclerosis  
 Multiple Sclerosis  
 Other (Please Specify) \_\_\_\_\_

Does the member have a prior history of hypersensitivity to Quinidine, Quinine, Mefloquine or dextromethorphan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Please indicate if the member has any of the following:			
<input type="checkbox"/> Prolonged QT interval	<input type="checkbox"/> Torsades de Pointes	<input type="checkbox"/> Complete AV block	<input type="checkbox"/> None
<input type="checkbox"/> Congenital Long QT syndrome	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Implanted Pacemaker	

Please indicate if the member is currently taking any of the following drugs:			
<input type="checkbox"/> Quinidine	<input type="checkbox"/> Mefloquine		
<input type="checkbox"/> Quinine	<input type="checkbox"/> Monoamine Oxidase Inhibitors (MAOI)	<input type="checkbox"/> None	

Please list all medications the member has previously tried or is currently using.

Medication Name	Strength	Frequency	Dates of Trial		List adverse reactions/side effects/reason for discontinuation
			Start Date	End Date	

Please provide any additional information which should be considered in the space below:
