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.

❑ New medication ❑ Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	❑Yes ❑No

Please indicate place of administration?	❑Physician Office ❑Hospital/Facility	**Please indicate how medication will be billed:** ❑ Billed directly by the provider via JCODE Provide JCODE:________________ ❑ Billed by a pharmacy and delivered to the provider ❑ 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) ☐ Yes ☐ No

If yes, please submit chart documentation to support the diagnosis of PBA

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? ☐ Yes ☐ No

Please indicate if the member has any of the following:

- ☐ Prolonged QT interval
- ☐ Congenital Long QT syndrome
- ☐ Torsades de Pointes
- ☐ Heart Failure
- ☐ Complete AV block without implanted pacemaker
- ☐ None

Please indicate if the member is currently taking any of the following drugs:

- ☐ Quinidine
- ☐ Quinine
- ☐ Mefloquine
- ☐ Monoamine Oxidase Inhibitors (MAOI)
- ☐ 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: