



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Nuedexta
Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, and Specialty/facility name.

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields for Drug Name, Strength, and Directions / SIG.

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have a diagnosis of pseudobulbar affect (PBA)?

Yes checkbox

No checkbox

Q2. Is the patient 18 years of age or older?

Yes checkbox

No checkbox

Q3. Is the prescriber a neurologist or in consultation with a neurologist?

Yes checkbox

No checkbox

Q4. Does the patient have any contraindications to Nuedexta (dextromethorphan hydrobromide and quinidine sulfate)?

Yes checkbox

No checkbox

Q5. Does the patient profile show any contraindicated drug interactions (Risk X) with Nuedexta (dextromethorphan hydrobromide and quinidine sulfate)?

Yes checkbox

No checkbox



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Patient Name:	Prescriber Name:
Q6. Has any plan been made to address the contraindicated drug-drug interactions, such as discontinuation, dose reduction of interacting drugs, counseling patient of the risks associated with the potentially significant drug-drug interaction? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. For patients at risk of QT prolongation and torsades de pointes, will the patient have a baseline EKG and an EKG evaluation 3-4 hours after the first dose? (Patients at high risk of QT prolongation and torsades de pointes include recipients concomitantly taking any CYP3A4 inhibitors or medication which may prolong the QT interval and recipients with left ventricular hypertrophy or left ventricular dysfunction.) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Does the patient have potassium and magnesium levels within normal range? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Does the patient have severe renal impairment (GFR less than 30)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. For Renewal: Does the patient have any contraindications to Nuedexta (dextromethorphan hydrobromide and quinidine sulfate)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Does the patient profile show any contraindicated drug interactions (Risk X) with Nuedexta (dextromethorphan hydrobromide and quinidine sulfate)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Has any plan been made to address the contraindicated drug-drug interactions, such as discontinuation, dose reduction of interacting drugs, counseling patient of the risks associated with the potentially significant drug-drug interaction? <input type="checkbox"/> Yes <input type="checkbox"/> No	



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Q13. Does the provider submit the following laboratory tests? A. Repeat EKG if risk factors for arrhythmia change during the course of treatment with Nuedexta. (Risk factors include concomitant use of drugs associated with QT prolongation, electrolyte abnormalities (potassium and magnesium), bradycardia, and family history of QT abnormality.); B. Potassium and magnesium levels ; C. Complete blood count (CBC); D. Liver Function Tests (LFT) ; E. GFR

Yes

No

Q14. Additional Information:

Prescriber Signature

Date

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