Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Nuedexta 20 mg-10 mg capsule
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Requested Quantity Per Rx – Amount:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____

(*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Pseudobulbar affect

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q4: Does the member have clinical benefit from ongoing therapy as demonstrated by a decrease in inappropriate laughing or crying episodes? (Check only one that apply)

[ ] Yes

[ ] No (please provide medical justification for the continuation of therapy)
_____(*Required)

Q5: What is the member's diagnosis? (Check only one that apply)

[ ] Pseudobulbar affect

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q6: Does the member have contraindication to concomitant use with other drugs containing quinidine, quinine, or mefloquine? (Check only one that apply)

[ ] Yes (please specify drug(s) name and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

Q7: Does the member have history of Nuedexta, quinine, mefloquine or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome? (Check only one that apply)

[ ] Yes (please specify drug(s) name and the start and end date(s) of therapy (month/year) and drug induced adverse event(s))
_____(*Required)

[ ] No

Q8: Does the member have known hypersensitivity to dextromethorphan (e.g., rash, hives)? (Check only one that apply)

[ ] Yes (please specify the hypersensitivity reactions(s)) _____
(*Required)

[ ] No

Q9: Is the member taking monoamine oxidase inhibitors (MAOIs) (e.g., phenelzine, selegiline, tranylcypromine) or have taken monoamine oxidase inhibitors within the preceding 14 days? (Check only one that apply)

[ ] Yes (please specify drug(s) name and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

Q10: Does the member have prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or has heart failure? (Check only one that apply)

[ ] Yes (please specify the disorder(s) and the date of onset) _____
(*Required)

[ ] No

Q11: Is the member receiving drugs that prolongs QT interval and are metabolized by CYP2D6 (e.g., thioridazine, pimozide)? (Check only one that apply)

[ ] Yes (please specify drug(s) name and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

Q12: Does the member have complete atrioventricular (AV) block without implanted pacemakers, or at high risk of complete atrioventricular (AV) block? (Check only one that apply)

[ ] Yes

[ ] No

Q13: Is the requested drug prescribed by or in consultation with a neurologist or psychiatrist? (Check only one that apply)

[ ] Yes (please specify prescriber specialty)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	