health information designs

Nuedexta
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Nuedexta must meet the following criteria:

Initial Criteria

- Patient must be 18 years of age or older
- Patient must not have a prolonged QT interval, heart failure, or complete atrioventricular block
- Patient's baseline CNS-LS and weekly PBA episode count must be provided
- Patient must have a diagnosis of PBA due to one of the following conditions: ALS, MS, Alzheimer's disease, or stroke
- **For PBA due to Alzheimer's disease or stroke**
  - Neurologic condition must have been stable for at least 3 months
  - Patient must have failed a 3-month trial of one medication from BOTH classes listed: SSRIs (sertraline, fluoxetine, citalopram and paroxetine) and Tricyclic Antidepressants (nortriptyline or amitriptyline)
    - A PBA episode count and CNS-LS score must be provided for before and after each trial

Renewal Criteria

- Benefit of renewal must be assessed
- Baseline and current PBA episode count must be included with request
- Current PBA episode count must be a 75 percent decrease from baseline
- **For PBA due to Alzheimer's disease or stroke**
  - Baseline and current Center for Neurological Studies lability (CNS-LS) must be included with request
  - Current CNS-LS score must be a 30% decrease from baseline

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request (include cause of PBA):**		
List all failed medications:	**Start Date (PBA Count at Start):**	**End Date (PBA Count at End):**	
Does the patient have a prolonged QT interval, heart failure, or complete atrioventricular (AV) block? □ YES □ NO Has the neurologic condition been stable for at least 3 months? □ YES □ NO			
Baseline CNS-LS:	Baseline weekly PBA episode count:	Current CNS-LS:	Current weekly PBA episode count:
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #