Acentra HEALTH

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 Medicaid

ND Medicaid requires that members receiving a prescription for Nuedexta to meet specific clinical criteria for coverage found at https://ndmedicaid.acentra.com/ndpdl/

Member Name	Member Date of Birth	Member Medicaid ID Number	
Prescriber Name	Prescriber NPI		
Telephone Number	Fax Number		
Address	City	State	Zip Code
Requested Drug, Strength, and Directions:		**Dosage Form (e.g., tablet):**	
Diagnosis for this request:	**Cause of PBA:**		

SECTION A: FOR ALL INITIAL REQUESTS:
1. Does the member have a prolonged QT interval, heart failure, or complete atrioventricular (AV) block? ☐ YES ☐ NO
☐ Baseline CNS-LS: _____
☐ Baseline weekly PBA Count: _____

SECTION B: FOR INITIAL REQUESTS FOR DIANGOSIS OF PBA DUE TO ALZHEIMER'S DISEASE OR STROKE ONLY (*please ensure section A is also completed*):
1. Has the neurologic condition been stable for at least 3 months? ☐ YES ☐ NO

List all failed medications:	**Start Date**	PBA Count (at start)	CNS-LS (at start)	**End Date**	PBA Count (at end)	CNS-LS (at end)

SECTION C: FOR ALL RENEWAL REQUESTS
1. Has the spontaneous improvement of PBA been ruled out? ☐ YES ☐ NO
☐ Current weekly PBA Count: _____

For PBA due to Alzheimer's disease or stroke:
☐ Current weekly PBA 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 member'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.*