BlueCross BlueShield Federal Employee Program

NUEDEXTA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Nuedexta

(dextromethorphan hydrobromide/quinidine sulfate)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Will the patient need more than 180 tablets every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ tablets every 90 days

2. Does the patient have a diagnosis of pseudobulbar affect (PBA)? ❑Yes ❑No

3. Does the prescriber agree to evaluate for a spontaneous improvement of PBA prior to request for renewal? ❑Yes ❑No

4. Has the patient been on Nuedexta continuously for the last **2 months**, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

   a. Does the patient have a concurrent diagnosis of one of the following: Alzheimer's disease or other dementias, stroke, traumatic brain injury (TBI), multiple sclerosis (MS), Parkinson's disease, or Lou Gehrig's disease (ALS)? ❑Yes ❑No

   b. Does the patient have a baseline ECG with no significant abnormalities and no history of QT prolongation syndrome? ❑Yes ❑No

   c. Does the patient have a history of complete AV (atrioventricular) block without an implanted pacemaker or is at high risk of complete AV block? ❑Yes ❑No

   d. Does the patient have a history of torsades de pointes, or heart failure? ❑Yes ❑No

   e. Does the patient have a baseline score of at least 13 on the *Center for Neurologic Studies-Lability Scale (CNS-LS)? ❑Yes ❑No
      ****Scale is available at* https://www.nuedextahcp.com/sites/default/files/pdf/CNS-LS-Questionnaire.pdf**

   f. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a selective serotonin reuptake inhibitor (SSRI) and a tricyclic antidepressant (TCA)? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

   a. Has there been a consultation with a neurologist to ascertain positive clinical response to therapy? ❑Yes ❑No

   b. Has the patient been assessed for spontaneous improvement? ❑Yes* ❑No
      If YES, have the patient's symptoms returned? ❑Yes ❑No

   c. Does the prescriber agree to reevaluate ECG if risk factors for arrhythmia change during the course of treatment? ❑Yes ❑No

   d. Has the patient's *CNS-LS score stabilized or decreased from baseline? ❑Yes ❑No
      ****Scale is available at* https://www.nuedextahcp.com/sites/default/files/pdf/CNS-LS-Questionnaire.pdf**