Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Nuedexta (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Nuedexta (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Nuedexta (dextromethorphan and quinidine sulfate)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ ICD Code: _____

Circle the appropriate answer for each question.

1. Is the patient 18 years of age or older? Y N
2. Does the patient have a diagnosis of Pseudobulbar Affect (PBA) related to a neurologic disorder (e.g., ALS, MS, Parkinson's Disease, a stroke, traumatic brain injury) verified by progress notes or discharge notes? Y N
3. Is this request for a continuation of therapy of Nuedexta? Y N

   [If no, then skip to question 5.]
4. Do progress notes or medical records demonstrate effectiveness of therapy? Y N

[No further questions.]

5. Is Nuedexta being prescribed or recommended by a specialist (e.g., neurologist)? Y N

   [Note: If prescriber is not a specialist, then the referral notes of the specialist must be submitted.]

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date