CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
NUEDEXTA PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date ☐☐ / ☐☐ / ☐☐☐☐ Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

*****All sections must be completed or the request will be returned.*****

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service: _____ Start Date: _____
Diagnosis (for this request):	Diagnosis Code (for this request):

Requested Medication	Quantity	Directions for Use

***Note: Dose may not exceed 2 capsules per day**

PA Requirements:

Nuedexta is being prescribed by or in consultation with a psychiatrist or neurologist ☐ Yes ☐ No

Member Diagnosis(es) for requested agent (please attach current documentation to support the diagnosis):

_____

_____

Does the member have any of the following:

- Thrombocytopenia or bone marrow suppression ☐ Yes ☐ No
- Lupus or lupus-like syndrome ☐ Yes ☐ No
- Heart failure, QT prolongation, AV block, or history of AV block ☐ Yes ☐ No
- Member currently taking other medications that can lead to QT prolongation ☐ Yes ☐ No
  Name of medication(s) _____
- Member taking MAOI therapy currently or within the past 14 days ☐ Yes ☐ No
  Name of medication(s) _____

I attest that the provided information above is accurate:

Physician Signature: _____ **Date:** _____