Prescriber Criteria Form
Nuedexta 2026 PA Fax 1441-A v1 010126.docx
Nuedexta (dextromethorphan hydrobromide/quinidine sulfate)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Nuedexta (dextromethorphan hydrobromide/quinidine sulfate).

Drug Name:
Nuedexta (dextromethorphan hydrobromide/quinidine sulfate)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of pseudobulbar affect (PBA)? [If no, then no further questions.]	Yes	No
2	Is this a request for continuation of therapy? [If no, then skip to question 4.]	Yes	No
3	Has the patient experienced a decrease in pseudobulbar affect (PBA) episodes since starting therapy with the requested drug? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of pseudobulbar affect (PBA) due to underlying neurological disease or injury? [If no, then no further questions.]	Yes	No
5	Is the patient experiencing pseudobulbar affect (PBA) episodes characterized by involuntary, sudden, and frequent episodes of laughing and/or crying?	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____