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

MDwise
Fax to: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.
Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131
Phone: (800) 788-2949

MDwise
A McLaren Company

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

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

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

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Quantity	Dosage Regimen

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

PA Requirements:
Member diagnosis(es) for requested agent:_____
Nuedexta is being prescribed by or in consultation with a psychiatrist or neurologist ☐ Yes ☐ No
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 • Member taking MAOI therapy currently or within the past 14 days ☐ Yes ☐ No