Prescriber Criteria Form Nuedexta 2025 PA Fax 1441-A v1 010125.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 no further questions.]	Yes ◯	No ◯
3	Has the patient experienced a decrease in pseudobulbar affect (PBA) episodes since starting therapy with the requested drug?	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:**_____