



**BlueCross  
BlueShield  
of Arizona**

An Independent Licensee  
of the Blue Cross and  
Blue Shield Association

**Precertification Request Form for  
Nuedexta®**

**Precertification for Nuedexta® requires completion of this form in its entirety.** All requested data must be provided. Once completed the form must be signed by the medical provider and faxed back to BCBSAZ Pharmacy Management at **(602) 864-3126**. Incomplete forms may result in denial of requested medication due to lack of needed information.

Provider Information			Patient Information		
Physician's Name			Patient's Name		
Physician Specialty		NPI #	BCBSAZ Member ID		
Mailing Address			Date of Birth / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
City	State	Zip Code	Patient's Address		
Phone # ( ) - ext		Fax # ( ) -	City	State	Zip Code

Medication Information	
Medication Name & Strength:	_____
Directions for Use & Duration:	_____
Diagnosis Code:	_____
Diagnosis:	_____

**All of the following questions must be answered:  
(Office notes are not needed if all information has been provided)**

Request is for Pseudobulbar affect secondary to which of the following:

<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	Amyotrophic Lateral Sclerosis

**I have ruled out the following conditions and/or circumstances:**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Heart failure
<input type="checkbox"/>	<input type="checkbox"/>	Risk for complete AV-block or has complete AV-block without implanted pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	History of or current evidence of prolonged QT-interval, or a history of congenital long QT-syndrome, or a history suggestive of torsades de pointes
<input type="checkbox"/>	<input type="checkbox"/>	Concurrent use of drugs that prolong QT-interval or drugs whose metabolism may be affected by Nuedexta that may result in prolonging the QT-interval
<input type="checkbox"/>	<input type="checkbox"/>	Concurrent use of a monoamine oxidase inhibitor (MAOI) or is within 14 days of stopping a MAOI
<input type="checkbox"/>	<input type="checkbox"/>	Risk for serotonin syndrome and/or use of certain selective serotonin reuptake inhibitors (SSRIs) or tricyclic antidepressants (TCAs) that increase risk for serotonin syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Concurrent use of Quinidine, Quinine, Mefloquine, or Dextromethorphan for other medical conditions
<input type="checkbox"/>	<input type="checkbox"/>	History of hypersensitivity reaction to Dextromethorphan
<input type="checkbox"/>	<input type="checkbox"/>	History of hypersensitivity reaction to either Quinidine, Quinine, or Mefloquine such as hepatitis, thrombocytopenia, or other significant reaction that suggests hypersensitivity
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy or likely to become pregnant or breast feeding

**Signature affirms that information given on this form is true and accurate and reflects office notes**

Physician's Signature – affirms that the information given on this form is true and accurate as of this date	Date
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