NUEDEXTA® Patient Services

PO BOX 42886 • CINCINNATI, OH 45242
PHONE: 1-855-4-NUEDEX (468-3339)
FAX: 1-877-788-4943

INSTRUCTIONS FOR COMPLETING YOUR PATIENT'S REQUEST

Please review carefully: If you provide incorrect or incomplete information, it may delay the processing of your request. Before mailing or faxing your application, be sure that you have completed the following information.

Please note that the process can also be completed online at www.NuedextaSupport.com.

CHECKLIST FOR PRIOR AUTHORIZATION OR BENEFIT VERIFICATION REQUESTS:

- ☐ PHYSICIAN MUST SIGN AND DATE THE REQUEST FORM
- ☐ COMPLETE THE FORM IN ITS ENTIRETY, INCLUDING:
  - ☐ Provider Information
  - ☐ Patient Information
  - ☐ Prescription Insurance Information
  - ☐ Reason for Request
  - ☐ Additional Comments
- ☐ COPY OF THE PATIENT'S PRESCRIPTION INSURANCE CARD (FRONT AND BACK)
- ☐ ATTACH ANY ADDITIONAL RELEVANT DOCUMENTATION OR CLINICAL INFORMATION

CHECKLIST FOR PATIENT ASSISTANCE REQUESTS:

- ☐ SIGN AND DATE THE REQUEST FORM
- ☐ COMPLETE THE FORM IN ITS ENTIRETY INCLUDING:
  - ☐ Provider Information
  - ☐ Patient Information
  - ☐ Prescription Insurance Information
- ☐ PATIENT MUST ATTACH A COPY OF THEIR MOST RECENT HOUSEHOLD INCOME DOCUMENTATION

NUEDEXTA®
(dextromethorphan HBr and quinidine sulfate) Capsules
20mg/10mg

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REQUEST FOR:

- ☐ Prior Authorization
- ☐ Benefit Verification
- ☐ Patient Assistance

PROVIDER INFORMATION

Name: _____ NPI: _____ Tax ID: _____

DEA#: _____ State License#: _____

Specialty: _____ Office Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____ Fax: _____

PATIENT INFORMATION

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ SSN: _____ US Resident: ☐ Yes ☐ No

For Patient Assistance Requests: Number of People in Household: _____ Gross Annual Household Income: _____

PRESCRIPTION INSURANCE INFORMATION (attach a copy of the front and back of the insurance card)

What type of prescription insurance do you have? (Check all that apply)

☐ Private Insurance ☐ Medicare Part D ☐ Medicaid ☐ Other (Please Indicate) _____

Prescription Plan Name: _____ Policy Holder Name: _____

Phone: _____ Fax: _____

Member ID: _____ Group ID: _____ RxBIN: _____

MEDICATION REQUESTED

☐ **Nuedexta Capsules, 60 per month**

DIAGNOSIS

☐ PBA ☐ Other: _____

REASON FOR REQUEST (for Prior Authorization only)

☐ No drug listed on formulary indicated for this condition ☐ Other: _____

ADDITIONAL COMMENTS (for Prior Authorization only)

I certify that this therapy is medically necessary and that this information is complete and accurate to the best of my knowledge. I authorize RxHope, a Triplefin Company ("RxHope") to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information in this form to the insurer of the above-named patient. I certify that I have obtained all necessary and proper consent and authorization from the patient (or from a parent of the patient, if applicable) to obtain and disclose any information about the patient, including any protected health information (as defined in 45 CFR 160.103), from the insurer, including eligibility and other benefit coverage information, for insurance coverage verification, payment and/or healthcare operation purposes. As my designated agent, my understanding is that RxHope will comply with the applicable requirements of 45 CFR 164.504(e) regarding designated agents, and that it will use reasonable efforts to safeguard any protected health information that it obtains on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by applicable law.

Physician Signature _____ Date: _____

I hereby authorize my insurer, either public or private, employer, hospital, physician, or any other healthcare provider to disclose to Avanir Pharmaceuticals and its agents all medical records and information, financial and insurance records and information as well as other identifying information for the purpose of my participation in the Nuedexta Patient Services program. I verify that the information provided is this application is complete and accurate and I have no prescription coverage for the prescribed treatment. I understand that Avanir Pharmaceuticals reserves the right at any time and without notice to modify the application or modify or discontinue this program and related eligibility criteria.

Patient Signature _____ Date: _____