Neuraceq® Prior Authorization (PA) Checklist

NeuraCeq® florbetaben F18 injection

Patient Contact & Insurance Information:

- ☐ Insurance In Network
  - ☐ Providers should check with payer/plan for coverage criteria and diagnosis.

Provider Information:

- ☐ Referring Provider Name
  - ☐ NPI and TIN
  - ☐ Specialty

Site of Service for Imaging:

- ☐ Name
  - ☐ Location
  - ☐ In-Network
- ☐ Independent Diagnostic Treatment Facility (IDTF)
- ☐ Hospital Outpatient (HOPPS)

Patient Diagnosis & Codes:

Type	Code	Description
HCPCS	Q9983	Neuraceq® – 1 billing unit per patient per dose
ICD-10	G31.84	Mild cognitive impairment
ICD-10	G30.0	Alzheimer's disease (AD), early onset
ICD-10	G30.1	AD, late onset
ICD-10	G30.8	Other AD
ICD-10	G30.9	AD, unspecified
This is not an exhaustive list. It is the responsibility of the HCP to provide accurate coding.		
NDC	54828-0001-50	NDC number to be attached to the claim
CPT	78814	PET/CT, limited area
CPT	78811	PET, limited area

Supporting Clinical Documentation:

Commonly requested records that help justify imaging but may not all be required.

Clinical/Progress Notes

- ☐ Clinical evaluations/notes (including Provider-Patient discussion of potential therapy if scan is positive)
- ☐ Medication List and History (including Anti-Beta Amyloid therapy, if applicable)

Imaging Reports

- ☐ Prior imaging results: MRI, CT and (including β-Amyloid, if applicable)

Mental Status Assessments

- ☐ MoCA, MMSE, MIS, Clinical Dementia Rating, Neuropsychological testing

Labs

- ☐ TSH, T4, B12, Folate, CBC, CMP

Management Plan for Patient

- ☐ Possible Anti-Amyloid Therapy
- ☐ Centiloid Quantification or SUVR, if applicable

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Common Denial Reasons & Next Steps Checklist

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Identify the Denial Type

Prior Authorization Denial
(Before scan is performed)

Claim Denial
(After scan is completed and billed)

If Denied Due to Prior Authorization

Common Reasons

- Authorization not obtained before service
- CPT code and diagnosis mismatch
- Insufficient clinical documentation
- Payer-specific criteria not met

Consider Response:

- [ ] Review denial letter for specific reasons and payer instructions
- [ ] Gather supporting documentation (e.g., MMSE/MoCA, labs, clinical notes)
- [ ] Reference RBM guidelines (e.g., eviCore, Carelon)
- [ ] Submit reconsideration or appeal with a Letter of Medical Necessity
- [ ] Contact your dedicated Account Reimbursement Manager for assistance

If Denied After Claim Submission

Common Reasons

- No prior authorization on file
- Incorrect coding (CPT, ICD-10, NDC)
- Site of service mismatch
- Missing or incomplete documentation
- Medical necessity not established

Consider Response:

- [ ] Review Explanation of Benefits (EOB) or denial notice
- [ ] Check and correct CPT/ICD-10/NDC codes
- [ ] Submit corrected claim or appeal with updated documentation
- [ ] Include detailed Letter of Medical Necessity
- [ ] Track timely filing deadlines for appeals
- [ ] Contact your dedicated Account Reimbursement Manager for assistance

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