HIGHMARK WHOLECARE

Updated: 08/2026
PARP Approved: 08/13/2026

Prior Authorization Criteria

Nuedexta (dextromethorphan hydrobromide and quinidine sulfate

All requests for Nuedexta (dextromethorphan hydrobromide and quinidine sulfate) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of pseudobulbar affect and the following criteria is met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- The member must be 18 years of age or older
- Must be prescribed by or in consultation with a neurologist
- Must have an underlying neurological disorder including but not limited to amyotrophic lateral sclerosis, multiple sclerosis, Alzheimer's and related diseases, stroke, traumatic brain injury, or Parkinsonian Syndrome.
- Documentation supporting both of the following:
    - Involuntary outbursts of laughing and/or crying that are incongruent or disproportionate to the member's emotional state
    - Other possible conditions that could result in emotional lability (e.g. depression, bipolar disorder, schizophrenia, epilepsy) have been ruled out.
- Documentation of baseline laughing/ and or crying episodes
- Provider attestation of ALL of the following:
    - The member is not receiving concomitant therapy with quinidine, quinine or mefloquine
    - The member has a recent EKG that does not show a prolonged QT interval or AV block without implanted
    - The member does not have a known history of heart failure, suggestive torsades de pointes, and is not at high risk for complete AV block
    - The requested medication will not use concomitantly with drugs that prolong QT interval and are metabolized by CYP2D6 (i.e. thioridazine or pimozide)
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    i. Documentation that the number of laughing and or crying episodes has decreased from baseline
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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NUEDEXTA (DEXTROMETHORPAN HYDROBROMIDE AND QUINIDINE SULFATE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Pseudobulbar Affect ☐ Other:	ICD Code:

Please submit documentation to support the above diagnosis

Does the member have an underlying neurologic disorder? ☐ Yes ☐ No
If yes please list:_____

Baseline average number of crying/laughing episodes per day: _____

Please mark all that apply:

☐ The member is not receiving concomitant therapy with quinidine, quinine or mefloquine

☐ The member has a recent EKG that does not show a prolonged QT interval or AV block without implanted

☐ The member does not have a known history of heart failure, suggestive torsades de pointes, and is not at high risk for complete AV block

☐ The requested medication will not use concomitantly with drugs that prolong QT interval and are metabolized by CYP2D6 (i.e. thioridazine or pimozide)

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

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NUEDEXTA (DEXTROMETHORPAN HYDROBROMIDE AND QUINIDINE SULFATE) PRIOR AUTHORIZATION FORM (CONTINUED)– PAGE 2 of 2

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MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REAUTHORIZATION

Has the member experienced an improvement with treatment? ☐ Yes ☐ No

Has the member experienced a decrease in the average number of laughing/crying episodes since starting the medication? ☐ Yes ☐ No
Baseline average number of crying/laughing episodes per day: _____
Current average number of crying/laughing episodes per day:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date