# Prior Authorization Criteria <br> 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:
o Involuntary outbursts of laughing and/or crying that are incongruent or disproportionate to the member's emotional state
o 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:
o The member is not receiving concomitant therapy with quinidine, quinine or mefloquine
o The member has a recent EKG that does not show a prolonged QT interval or AV block without implanted
o 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
o 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.


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

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

## MEMBER INFORMATION



