Updated: 11/2018
PARP Approved: 11/2018

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
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - 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.

Gateway Health

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NUEDEXTA
PRIOR AUTHORIZATION FORM

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

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a 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: _____
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: _____

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

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