Updated: 8/2019
DMMA Approved: 8/2019

Request for Prior Authorization for Nuedexta (dextromethorphan hydrobromide and quinidine sulfate)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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.

Nuedexta (dextromethorphan hydrobromide and quinidine sulfate) Prior Authorization Criteria:

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 average laughing/ and or crying episodes per day
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Documentation that the average 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.

Highmark Delaware HEALTH OPTIONS

Updated: 8/2019
DMMA Approved: 8/2019

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 Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 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:
Health Options 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:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

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)

Updated: 8/2019
DMMA Approved: 8/2019

Member Name:		DOB:	
Highmark Health Options ID			

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