HIGHMARK HEALTH OPTIONS

Updated: 09/2023
DMMA Approved: 09/2023

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 (PBA) 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
- 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**
    - Documentation that the average number of laughing and or crying episodes has decreased from baseline

Reauthorization Duration of Approval: 12 months

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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 Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
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:	

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:_____

Have Other possible conditions that could result in emotional lability (e.g. depression, bipolar disorder, schizophrenia, epilepsy) have been ruled out? ☐ Yes ☐ No

Does the member have involuntary outbursts of laughing and/or crying that are incongruent or disproportionate to the member's emotional state? ☐ Yes ☐ No

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

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Member Name: DOB:
Member ID

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)

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