



Updated: 07/2025
DMMA Approved: 07/2025

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Billing Information

This medication will be billed: <input type="checkbox"/> at a pharmacy OR <input type="checkbox"/> medically (if medically please provide a JCODE:
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> 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: _____

Member Name:		DOB:	
Member ID			
Please mark all that apply: <input type="checkbox"/> The member is not receiving concomitant therapy with quinidine, quinine or mefloquine <input type="checkbox"/> The member has a recent EKG that does not show a prolonged QT interval or AV block without implanted <input type="checkbox"/> 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 <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	



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