

**NUEDEXTA (dextromethorphan/quinidine) PRIOR AUTHORIZATION FORM**

- Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Nuedexta (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages in request: _____	Prescriber name: _____
Name of office contact: _____		Specialty: _____	
Contact's phone number: _____		State license #: _____	
LTC facility contact/phone: _____		NPI: _____	MA Provider ID#: _____
RECIPIENT INFORMATION		Street address: _____	
Recipient Name: _____		Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____

**CLINICAL INFORMATION**

<b>Nuedexta 20 mg/10 mg capsule</b>	Dose/directions: _____	Quantity: _____	Refills: _____
Diagnosis ( <u>submit documentation</u> ): _____		Dx code ( <u>required</u> ): _____	

**Initial requests: complete sections A and B; Renewal requests: complete sections A and C**

**Section A: All requests**

1. Is the Recipient taking any medications that are contraindicated for use with Nuedexta?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of Recipient's current complete medication list</i>
2. Have all drug interactions that may occur between Nuedexta and the Recipient's current medications been addressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Section B: Initial requests**

1. Check all of the following that apply to the Recipient, and submit supporting medical documentation for each.

<input type="checkbox"/> has documentation of recent potassium and magnesium levels within normal limits	<input type="checkbox"/> does not have a known sensitivity to dextromethorphan
<input type="checkbox"/> does not have severe renal impairment, i.e., a GFR < 30 ml/min	<input type="checkbox"/> is not at high risk for complete AV block
<input type="checkbox"/> does not have a known history of heart failure or history suggestive of torsades de pointes	<input type="checkbox"/> does not have a history of quinidine-, quinine-, or mefloquine-induced thrombocytopenia, hepatitis, or other hypersensitivity reactions
<input type="checkbox"/> does not have a prolonged QT interval or AV block (without implanted pacemaker) as demonstrated by recent EKG results	

2. If the Recipient is at high risk of QT prolongation and torsades de pointes, does the Recipient have results of a baseline EKG and will the Recipient have an EKG 3-4 hours after the first dose of Nuedexta?

Yes → submit documentation of baseline EKG results and EKG monitoring plan  
 No

**Section C: Renewal requests**

1. Did the Recipient experience improvement in symptoms of pseudobulbar affect (PBA) since starting Nuedexta?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of Recipient's response to treatment</i>
2. Has the Recipient had the following recommended monitoring to ensure the safety of continued use of Nuedexta? <u>Check all that apply.</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of recent lab results obtained since starting Nuedexta</i>
<input type="checkbox"/> potassium and magnesium levels <input type="checkbox"/> liver function tests (LFTs) <input type="checkbox"/> complete blood count (CBC) <input type="checkbox"/> glomerular filtration rate (GFR)		
3. Does the Recipient have any of the following risk factors for arrhythmia?	<input type="checkbox"/> Yes → <u>submit documentation of repeat EKG results</u> <input type="checkbox"/> No	
<input type="checkbox"/> bradycardia <input type="checkbox"/> currently taking a drug associated with QL prolongation <input type="checkbox"/> electrolyte abnormalities <input type="checkbox"/> family history of QT abnormality		

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

<b>Prescriber Signature:</b> _____	<b>Date:</b> _____
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