

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

Nuedexta 20 mg/10 mg capsule	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>
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

Prescriber Signature:	Date:
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