pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

NUEDEXTA (dextromethorphan/quinidine) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Nuedexta (dextromethorphan/quinidine)** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Nuedexta 20 mg/10 mg capsule	Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Is the beneficiary taking any medications that are contraindicated for use with Nuedexta (other drugs containing quinidine, quinine, mefloquine, MAO inhibitors)?	☐Yes ☐No	*Submit documentation of beneficiary's current complete medication list.*
Is the beneficiary is taking any medications that interact with Nuedexta? *Submit documentation showing how the interaction(s) has been addressed.*	☐Yes ☐No	

INITIAL requests

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

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

If the beneficiary is at high risk of QT prolongation and torsades de pointes, does the beneficiary have results of a baseline EKG and will the beneficiary have an EKG 3-4 hours after the first dose of Nuedexta?	☐Yes → *Submit documentation of baseline EKG results and EKG monitoring plan.* ☐No

RENEWAL requests

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

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

Prescriber Signature:	**Date**:

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