

**Montana Healthcare Programs Prior Authorization Request Form  
for Use of Nuedexta (dextromethorphan/quinidine)**

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty:	Prescriber Fax:	

**Please complete below information for applicable situation, Initiation or Continuation of therapy:**

**☐ INITIATION OF THERAPY**

1. Member has been diagnosed with pseudobulbar affect (PBA) by a neurologist: ☐ Yes ☐ No

Name of neurologist: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

2. Approval will be granted only for members with PBA secondary to neurological conditions or injuries:

☐ Amyotrophic lateral sclerosis (ALS)

☐ Multiple sclerosis (MS)

☐ Traumatic brain injury (TBI)

☐ Stroke

☐ Other: \_\_\_\_\_

3. Member **does not** have any of the following contraindications (all must be checked):

☐ Concomitant use of quinidine, quinine or mefloquine

☐ Known hypersensitivity to dextromethorphan

☐ Current monoamine oxidase inhibitor (MAOI) use or within 14 days of stopping a MAOI

☐ Prolonged QT interval, congenital long QT syndrome, history suggestive of torsade's de pointes or heart failure

☐ Complete atrioventricular (AV) block without implanted pacemaker, or member at high risk of complete AV block

☐ Concomitant use of drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., paroxetine, fluoxetine, thioridazine, pimozide).

**LIMITATIONS:**

Initial authorization: A maximum daily dose of 2 capsules will be allowed.

**Initial authorization will be issued for 6 months.**

☐ **CONTINUATION OF THERAPY**

Does the member have documentation of a significant positive clinical response to Nuedexta therapy (e.g., reduction in number of laughing or crying episodes, as well as other markers of improved emotional control)?

☐ Yes   ☐ No [*attach supporting chart notes*]

**Reauthorization will be issued for 12 months.**

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**Please complete form, including required attachments and fax to  
Drug Prior Authorization Unit at 1-800-294-1350.**

09/2022