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

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.

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

09/2022