UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Nuedexta (dextromethorphan/quinidine)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met)

1. Does the patient have a diagnosis of pseudobulbar affect caused by a structural neurologic condition (e.g., amyotrophic lateral sclerosis [ALS], multiple sclerosis [MS] or stroke)? ❑ **Yes** ❑ **No**
2. Is the medication being prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**
3. Has the patient **NOT** used MAOIs within the past 14 days? ❑ **Yes** ❑ **No**
4. Has the patient tried and failed at least two of the following medications? ❑ **Yes** ❑ **No**
   - ☐ Tricyclic antidepressant (TCA) Medication: _____
     Details of Failure: _____
   - ☐ Selective serotonin reuptake inhibitor (SSRI) Medication: _____
     Details of Failure: _____
   - ☐ Serotonin norepinephrine reuptake inhibitor (SNRI) Medication: _____
     Details of Failure: _____
5. Does the patient have a baseline ECG with no significant abnormalities and no history of QT prolongation syndrome? ❑ **Yes** ❑ **No**
6. Has the patient had at least 10 episodes of inappropriate laughing or crying per day before therapy? ❑ **Yes** ❑ **No**

Reauthorization Criteria:

1. Has the provider submitted an updated letter or medical necessity or updated chart notes demonstrating the patient has had a positive clinical response? ❑ **Yes** ❑ **No**
2. Has the provider submitted documentation showing a 50% decrease in the number of inappropriate episodes of laughing or crying compared to baseline (before Nuedexta was started)? ❑ **Yes** ❑ **No**

Initial Authorization: Up to three (3) months
Reauthorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date