Louisiana Medicaid
Dextromethorphan Hydrobromide/Quinidine Sulfate (Nuedexta®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for dextromethorphan hydrobromide/quinidine sulfate (Nuedexta®).

Additional Point-of-Sale edits may apply.

*This agent may have a **Black Box Warning** and may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety regulations. Please refer to individual prescribing information for details.*

Approval Criteria

- The ~~R~~recipient is 18 years of age or older on the date of the request; **AND**
- The ~~R~~recipient has a diagnosis of pseudobulbar affect (PBA); **AND**
- The ~~R~~recipient has a diagnosis of **ONE** of the following neurological disorders:
    - Alzheimer's disease; **OR**
    - Amyotrophic lateral sclerosis (ALS); **OR**
    - Extrapyramidal and cerebellar disorders (such as Parkinson's disease, multiple system atrophy, and progressive supranuclear palsy); **OR**
    - Multiple sclerosis; **OR**
    - Traumatic brain injury; **OR**
    - Stroke; **OR**
    - Brain tumor; **AND**
- Dextromethorphan hydrobromide/quinidine sulfate (Nuedexta®) is being prescribed by, or the requests states that this medication is being prescribed in consultation with~~,~~ a neurologist, psychiatrist or medical psychologist; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of dextromethorphan hydrobromide / quinidine sulfate (Nuedexta®); **AND**
    - The recipient will not be receiving dextromethorphan hydrobromide / quinidine sulfate (Nuedexta®) in combination with any medication that is contraindicated or not recommended per FDA labeling; **AND**
    - The recipient does not have prolonged QT interval, congenital long QT syndrome, history suggestive of torsades de pointes, or heart failure; **AND**
    - The recipient does not have complete AV (atrioventricular) block without an implanted pacemaker or be at high risk of complete AV block.

Duration of initial approval: 3 months

Reauthorization Criteria

- The recipient continues to meet initial approval criteria; **AND**
- The recipient has had a positive response to treatment as evidenced by a decrease in the number of laughing and/or crying episodes, and this is **stated on the request.**

Duration of reauthorization approval: 12 months

References

Ahmed A, Simmons Z. Pseudobulbar affect: prevalence and management. *Therapeutics and Clinical Risk Management.* 2013;9: 483-489

Nuedexta® (dextromethorphan hydrobromide / quinidine sulfate) [package insert]. Aliso Viejo, CA: Avanir Pharmaceuticals; Juneanuary 2019. https://www.nuedexta.com/sites/default/files/Prescribing_Information.pdf

Revision / Date	**Implementation Date**
Policy created / October 2019	March 2020
Removed POS wording, formatting changes / May 2021	January 2022
Expanded prescriber specialty to include psychiatrist and medical psychologist, formatting changes, updated references / December 2021	July 2022