

**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®).

**Approval Criteria**

- Recipient is 18 years of age or older on the date of the request; **AND**
- Recipient has a diagnosis of pseudobulbar affect (PBA); **AND**
- 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; **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**

**Point-of-Sale Quantity Limit: 60 tabs / 30 days**

*Additional edits may apply at Point-of-Sale (POS). Override options may be available. For more information, refer to the Louisiana Department of Health Pharmacy Benefits Management Services Manual at [www.lamedicaid.com/provweb1/Providermanuals/manuals/PHARMACY/PHARMACY.pdf](http://www.lamedicaid.com/provweb1/Providermanuals/manuals/PHARMACY/PHARMACY.pdf)*

### **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; January 2019.  
[https://www.nuedexta.com/sites/default/files/Prescribing\\_Information.pdf](https://www.nuedexta.com/sites/default/files/Prescribing_Information.pdf)

<b>Revision</b>	<b>Date</b>
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