SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: dextromethorphan hydrobromide and quinidine sulfate (Nuedexta®)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy – provide therapy start date: _____

Recommended Dosing: Oral: Dextromethorphan 20 mg/quinidine 10 mg once daily for 7 days, then increase to dextromethorphan 20 mg/quinidine 10 mg every 12 hours; reassess patient periodically to determine if continued use is necessary. Do not exceed dextromethorphan 40 mg/quinidine 20 mg in a 24-hour period

Quantity Limit: 2 capsules per day

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Authorization Length: 12 months

- ❑ Member is at least 18 years of age

AND

(Continued on next page)

- ❑ Member has a diagnosis of pseudobulbar affect (PBA) associated with **(check one):**
  - ❑ Multiple Sclerosis
  - ❑ Amyotrophic Lateral Sclerosis (ALS)
  - ❑ Stroke
  - ❑ Traumatic Brain Injury

AND

- ❑ Member does **NOT** have a depression diagnosis or depression is currently managed

Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee**: 5/19/2011
REVISED/UPDATED/REFORMATTED: ~~9/13/2011; 4/10/2014; 11/6/2014; 5/22/2015; 7/16/2015; 8/11/2015; 12/28/2015; 12/19/2016; 8/15/2017; 6/19/2019; 10/30/2023;~~ **10/16/2026**