HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
NUEDEXTA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Nuedexta® (dextromethorphan 20mg and quinidine 10mg)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider a neurologist?	☐	☐	
3. Does the member have a documented diagnosis of pseudobulbar affect (PBA) secondary to at least one of the following: • Amyotrophic lateral sclerosis • Multiple sclerosis • Ischemic or hemorrhagic stroke • Traumatic brain injury • Dementia – including Alzheimer's disease, Vascular, Lewy body, or Frontotemporal Dementia	☐	☐	**Please provide documentation**
4. Has the underlying condition been stable for at least the past 2 months?	☐	☐	**Please provide documentation**
5. Is there documentation of a baseline Center for Neurologic Studies Lability Score (CNS-LS)?	☐	☐	**Please provide documentation**
6. Does the member show clinical symptoms of episodes of sudden uncontrollable and inappropriate laughing or crying?	☐	☐	**Please provide documentation**
7. Is the member's baseline PBA score ≥ 13?	☐	☐	**Please provide documentation**
8. Have the member's number of PBA episodes per day been documented?	☐	☐	**Please provide documentation**

9. Has the member had a 3-month trial and failure of, or contraindication to, both of the following medication classes: • tricyclic antidepressant (TCA) • selective serotonin reuptake inhibitor (SSRI)	☐	☐	**Please provide documentation**
10. Does documentation show a baseline EKG with any significant abnormalities and/or does the member have a history of QT prolongation syndrome?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 weeks with a neurologist?	☐	☐	
3. Has the requesting provider evaluated for a spontaneous improvement of PBA prior to this renewal request?	☐	☐	**Please provide documentation**
4. Does the requesting prescriber agree to re-evaluate EKG if risk factors change during the course of treatment?	☐	☐	
5. Has the member shown a decrease in CNS-LS score?	☐	☐	**Please provide documentation**
6. Has the member shown at least a 30% improvement in the number of PBA episode per day from baseline?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-CHIP-083
Origination Date: 07/01/2024
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 06/01/2025