UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Nuedexta

Program	Prior Authorization
Medication	Nuedexta (dextromethorphan HBr/quinidine)
Markets in Scope	Arizona, California, Hawaii, Maryland, New Jersey, Nevada, New York, New York EPP, Pennsylvania- CHIP, Rhode Island, South Carolina
Issue Date	6/2011
Pharmacy and Therapeutics Approval Date	7/2020
Effective Date	9/2020

1. Background:

Nuedexta, a combination product containing dextromethorphan hydrobromide and quinidine sulfate, is indicated for the treatment of pseudobulbar affect (PBA). PBA occurs secondary to a variety of neurologic conditions, and is characterized by involuntary, sudden, and frequent episodes of laughing and/or crying. PBA episodes typically occur out of proportion or are incongruent to the underlying emotional state. PBA is a specific condition, distinct from other types of emotional lability that may occur in patients with neurological disease or injury.

2. Coverage Criteria:

A. <u>Authorization</u>

1. Diagnosis of pseudobulbar affect (PBA)

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References

1. Nuedexta [package insert]. Aliso Viejo, CA: Avanir Pharmaceuticals, Inc.; January 2019.

Program	Prior Authorization- Nuedexta (dextromethorphan HBr/quinidine)
Change Control	
Date	Change
6/2011	New drug policy
8/2011	Requirement that the prescriber is a neurologist Initial authorization period changed to 6 months Reauthorization criteria requires documentation of the benefit of Nuedexta therapy
6/2012	Annual Review
6/2013	Converted policy to new UHC enterprise wide formatting. Removed requirement that the patient has underlying ALS or MS Decreased initial authorization to 3 months
12/2015	Annual Review
11/2016	Updated policy template. Removed extra sections not related to clinical criteria.
3/2017	Updated policy template
9/2017	Removed prescriber check and updated authorization duration to 12 months. Removed reauthorization criteria to allow for Dx to Rx implementation.
10/2018	Annual review. Updated background and references.
11/2019	Annual review. Updated background and references.
7/2020	Annual review. Added Additional Clinical Rules and updated references.