

Pharmacy Medical Necessity Guidelines: Nuedexta (dextromethorphan /quinidine)

Effective: July 20, 2020

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
<p>These pharmacy medical necessity guidelines apply to the following:</p> <p>Commercial Products</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Tufts Health Plan Commercial products – large group plans <input checked="" type="checkbox"/> Tufts Health Plan Commercial products – small group and individual plans <input checked="" type="checkbox"/> Tufts Health Freedom Plan products – large group plans <input checked="" type="checkbox"/> Tufts Health Freedom Plan products – small group plans • CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization <p>Tufts Health Public Plans Products</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product) <input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans <input type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan 		<p>Fax Numbers:</p> <p>RXUM: 617.673.0988 MM: 888.415.9055 PRECERT: 617.972.9409</p>	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

Nuedexta (dextromethorphan/quinidine) is indicated for the treatment of pseudobulbar affect (PBA). PBA occurs secondary to a variety of otherwise unrelated neurological conditions, and is characterized by involuntary, sudden, and frequent episodes of laughing and/or crying. PBA episodes typically occur out of proportion or incongruent to the patient's underlying emotional state.

COVERAGE GUIDELINES

The plan may authorize coverage of Nuedexta (dextromethorphan/quinidine) for Members, when the following criterion is met:

1. Documented diagnosis of pseudobulbar affect

LIMITATIONS

1. Samples, free goods, or similar offerings of the requested medication do not qualify for an established clinical response or exception but will be considered on an individual basis for prior authorization.

CODES

None

REFERENCES

1. Colamonico J, Formella A, Bradley W. Pseudobulbar Affect: burden of illness in the U.S.A. *Adv Ther.* 2012 Sep;29(9):775-98. doi: 10.1007/s12325-012-0043-7. Epub 2012 Aug 30.
2. No authors listed. Dextromethorphan/quinidine (Nuedexta) for pseudobulbar affect. *Med Lett Drugs Ther.* 2011 Jul 11;53(1366):46-7.
3. Nuedexta (dextromethorphan/quinidine) [package insert]. Aliso Viejo, CA: Avanir Pharmaceuticals, Inc; January 2016.

APPROVAL HISTORY

May 10, 2011: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. April 10, 2012: No change
2. March 12, 2013: No changes
3. March 11, 2014: No changes
4. March 10, 2015: Remove the criteria of a diagnosis secondary to amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), or Bilateral Stroke.
5. January 1, 2016: Administrative change to rebranded template applicable to Tufts Health Direct.
6. March 8, 2016: No changes.

7. February 14, 2017: No changes. Effective 02/14/17, Medical Necessity Guideline applies to Tufts Health Together.
8. April 11, 2017: Administrative update. Effective 6/1/2017, Medical Necessity Guideline applies to Tufts Health RITogether.
9. February 13, 2018: No changes
10. February 12, 2019: Administrative update to the template.
11. July 14, 2020: Added the following limitation: Samples, free goods, or similar offerings of the requested medication do not qualify for an established clinical response or exception but will be considered on an individual basis for prior authorization.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

[Provider Services](#)