PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

NAMENDA (all dosage forms)
(memantine hydrochloride)

Prior Authorization applies only to patients less than 30 years of age.

Status: CVS Caremark Criteria
Type: Initial Prior Authorization with Age Edit

POLICY

FDA-APPROVED INDICATIONS
Namenda and Namenda XR are indicated for the treatment of moderate to severe dementia of the Alzheimer's type.

COVERAGE CRITERIA
The requested drug will be covered with prior authorization for patients less than 30 years of age when the following criteria are met:

- The patient has a diagnosis of moderate to severe dementia of the Alzheimer's type

REFERENCES

1. Namenda [package insert]. Irvine, CA: Allergan USA, Inc.; August 2016.
2. Namenda XR [package insert]. Irvine, CA: Allergan USA, Inc.; October 2016.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed May 2018.
4. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed May 2018.
5. Rabins P, Blacker D, Rovner B. Practice Guideline for the Treatment of Patients with Alzheimer's Disease and Other Dementias, Second Edition. *Am J Psychiatry*. 2007; 164(12S):1-56.
6. Qaseem A, Snow V, Cross T, et al. Current Pharmacological Treatment of Dementia: A Clinical Practice Guideline from the American College of Physicians and the American Academy of Family Physicians. *An Intern Med* 2008; 148:370-378.
7. Goldman JS, Hahn SE, Catania JW, et. al. ACMG Practice Guidelines. Genetic counseling and testing for Alzheimer disease: Joint practice guidelines of the American College of Medical Genetics and the National Society of Genetic Counselors. *Genetics in Medicine* June 2011; 13:597-605.