# **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]. Madison, NJ: Allergan USA, Inc.; November 2018.
- 2. Namenda XR [package insert]. Irvine, CA: Allergan USA, Inc.; October 2016.
- 3. Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. http://www.micromedexsolutions.com/. Accessed May 2019.
- 4. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: Wolters Kluwer Clinical Drug Information, Inc. http://online.lexi.com/. Accessed May 2019.
- 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.

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