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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