Clinical Policy Title:	pyridostigmine oral solution
Policy Number:	RxA.227
Drug(s) Applied:	Mestinon®
Original Policy Date:	02/07/2020
Last Review Date:	08/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Myasthenia Gravis (must meet all)**:**

1. Diagnosis of myasthenia gravis;
2. Documentation supports inability to use generic pyridostigmine tablets (e.g., inability to swallow pill due to young age, disease with bulbar involvement).

Approval Duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Myasthenia Gravis (must meet all)**:**

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval Duration

All Lines of Business (except Medicare): 12 months

References

1. Narayanaswami P, Sanders DB, Wolfe G, et al. International consensus guidance for management of myasthenia gravis: 2020 update. *Neurology*. 2021;96(3):114-122. Available at: https://n.neurology.org/content/96/3/114. Accessed August 28, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed: 1. Policy title table was updated: Clinical Policy Title was updated to "pyridostigmine"; Drug(s) Applied was updated to "Mestinon®"; Line of Business Policy Applies to was updated to "All". 2. Clinical policy was updated: Approval duration was updated for both Initial and Continued Approval Criteria; Continued Approval was rephrased to "Currently	08/01/2020	09/14/2020

receiving medication that has been authorized by RxAdvance or member has previously met initial approval criteria listed in this policy". 3. References were updated.		
Policy was reviewed: 1. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 2. Therapeutic Alternatives verbiage was rephrased to "Below are suggested therapeutic alternatives based on clinical guidance..". 3. References were reviewed and updated.	07/12/2021	09/14/2021
Policy was reviewed: 1. References were reviewed and updated.	02/04/2022	04/18/2022
Policy was reviewed: 1. References were reviewed and updated.	12/29/2022	04/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed dose restrictions. 2. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 3. Removed reauthorization requirement for positive response to therapy. 4. Updated approval duration verbiage. 5. Reference was reviewed and updated.	08/28/2024	09/13/2024