Clinical Policy Title:	memantine, memantine/donepezil
Policy Number:	RxA.242
Drug(s) Applied:	Namenda XR®, Namzaric®
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. Moderate to Severe Dementia (must meet all):

1. Diagnosis of moderate to severe dementia;
2. Trial and failure of donepezil, unless contraindicated or clinically significant adverse effects are experienced;
3. If request is for Namzaric, medical justification supports inability to use the individual generic components of donepezil and memantine.

Approval Duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Moderate to Severe Dementia (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. Rabins PV, Rovner BW, Rummans T, Schneider LS, Tariot PN. Guideline watch (October 2014): Practice guideline for the treatment of patients with Alzheimer's disease and other dementias. American Psychiatric Association. 2014. Available online at: https://psychiatry.org/File%20Library/Psychiatrists/Practice/Clinical%20Practice%20Guidelines/alzheimers.pdf. Accessed August 28, 2024.
2. The American Geriatrics Society. A Guide to Dementia Diagnosis & Treatment. Available at: http://www.americangeriatrics.org/. 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. 2. Continued therapy criteria II.A.1 was rephrased to	07/23/2020	09/14/2020

"Currently receiving medication that has been authorized by RxAdvance…". 3. Approval duration for Initial approval and Continued therapy criteria was updated to include Commercial and Medicaid plan. 4. "QD" was updated with once daily in document. 5. References were updated.		
Policy was reviewed 1. Policy title was updated. 2. Continued therapy criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance.." 3. References were reviewed and updated.	03/15/2021	6/10/2021
Policy was reviewed 1. References were reviewed and updated.	01/10/2022	04/18/2022
Policy was reviewed: 1. References were reviewed and updated.	12/27/2022	4/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed age restrictions. 2. Removed dose restrictions. 3. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 4. Removed reauthorization requirement for positive response to therapy. 5. Updated approval duration verbiage. 6. References were reviewed and updated.	08/28/2024	9/13/2024