# 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.
5. 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.