PRIOR AUTHORIZATION CRITERIA

BRAND NAME (generic)

NAMENDA (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, Namenda XR, and memantine hydrochloride oral solution are indicated for the treatment of moderate to severe dementia of the Alzheimer's type.

Compendial Uses

Vascular Dementia5-7

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 any of the following diagnoses: A) Moderate to severe dementia of the Alzheimer's type, B)
Vascular dementia

AND

If the request is for continuation of therapy, the medication continues to provide benefit to the patient
[Note: If slowing decline of cognitive function is no longer a goal, or if the patient is rapidly declining, treatment with the medication is no longer appropriate.]

OR

 If the request is NOT for continuation of therapy, the diagnosis is supported by a validated cognitive assessment within the past 12 months

Duration of Approval (DOA):

• 511-B: DOA: 12 months

REFERENCES

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- 6. Orgogozo JM, Rigaud AS, Stoffler A, et al. Efficacy and Safety of Memantine in Patients with Mild to Moderate Vascular Dementia. *Stroke*. 2002;33:1834-39.
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Namenda PA with Age Policy 511-B UDR 06-2023

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