Clinical Policy: Memantine ER (Namenda XR), Memantine/Donepezil (Namzaric)
Reference Number: CP.CPA.195
Effective Date: 11.16.16
Last Review Date: 08.18
Line of Business: Commercial

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The following are antidementia agents requiring prior authorization: memantine extended release (Namenda XR®) and memantine/donepezil hydrochloride (Namzaric™).

FDA Approved Indication(s)
Namenda XR is indicated for the treatment of moderate to severe dementia Alzheimer’s type.

Namzaric is indicated for the treatment of moderate to severe dementia of the Alzheimer’s type in patients stabilized on 10 mg of donepezil hydrochloride once daily.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Namenda XR/Namzaric are medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Moderate to Severe Dementia (must meet all):
      1. Diagnosis of moderate to severe dementia;
      2. Age ≥ 18 years;
      3. Failure of donepezil at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
      4. If request is for Namzaric, medical justification supports inability to use the individual generic components of donepezil and memantine;
      5. Dose does not exceed (a or b):
         a. Namenda XR: 28 mg per day;
         b. Namzaric: 28/10 mg per day.

   Approval duration:
   Medicaid – 12 months
   Commercial – Length of Benefit

B. Other diagnoses/indications
   1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial.
II. Continued Therapy
A. Moderate to Severe Dementia (must meet all):
   1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   2. Member is responding positively to therapy;
   3. If request is for a dose increase, new dose does not exceed (a or b):
      a. Namenda XR: 28 mg per day;
      b. Namzaric: 28/10 mg per day.

   Approval duration:
   Medicaid – 12 months
   Commercial – Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2):
   1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
   2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial.

III. Diagnoses/Indications for which coverage is NOT authorized:
   A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial or evidence of coverage documents.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   FDA: Food and Drug Administration

   Appendix B: Therapeutic Alternatives
   This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>donepezil (Aricept®/Aricept ODT®)</td>
<td>Mild to moderate: 5 mg to 10 mg orally once daily</td>
<td>10 mg/day</td>
</tr>
<tr>
<td></td>
<td>Moderate to severe: 10 to 23 mg orally once daily</td>
<td>23 mg/day</td>
</tr>
</tbody>
</table>

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

   Appendix C: Contraindications
   Not applicable
Appendix D: General Information

- Per the American Psychiatric Association practice guidelines for the treatment of Alzheimer’s, there is modest data that the combination of Namenda® and Aricept® is better than Aricept® alone, and there is no evidence that the combination is better than monotherapy with Namenda®.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memantine ER (Namenda XR)</td>
<td>Moderate to severe dementia of the Alzheimer’s type</td>
<td>Initial dose 7 mg once daily, increase by 7 mg per day at one-week intervals</td>
<td>28 mg once daily</td>
</tr>
<tr>
<td>Memantine/donepezil (Namzaric)</td>
<td>Moderate to severe dementia of the Alzheimer’s type</td>
<td>Initial dose 7 mg/10 mg once daily, increased in 7 mg increments per week</td>
<td>28/10 mg once daily</td>
</tr>
</tbody>
</table>

VI. Product Availability

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Availability</th>
</tr>
</thead>
</table>
| Namenda XR | Capsule: 7 mg, 14 mg, 21 mg, 28 mg
|           | Titration pack: 7 x 7 mg, 7 x 14 mg, 7 x 21 mg, 7 x 28 mg                                       |
| Namzaric  | Capsule: 7 mg/10 mg, 14 mg/10 mg, 21/10 mg, 28 mg/10 mg                                        |

VII. References

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3Q 2018 annual review: policy split from CP.CPA.102 and combined with CP.CPA.122; no significant changes from previously approved corporate policy; references reviewed and updated.</td>
<td>04.09.18 08.18</td>
</tr>
</tbody>
</table>

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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