# Clinical Policy: Memantine ER (Namenda XR), Memantine/Donepezil (Namzaric)

Reference Number: CP.CPA.195
Effective Date: 11.16.16
Last Review Date: 08.19
Line of Business: Commercial

Revision Log

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

## Description

The following are agents containing an N-methyl-D-aspartate (NMDA) receptor antagonist and 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 of the 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 and 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 mg/10 mg per day.

**Approval duration:** 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 mg/10 mg per day.

**Approval duration:** 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
NMDA: N-methyl-D-aspartate

*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.*

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| donepezil (Aricept®/Aricept ODT®) | Mild to moderate Alzheimer's disease: 5 mg to 10 mg PO QD | 10 mg/day |
| | Moderate to severe Alzheimer's disease: 10 to 23 mg PO QD | 23 mg/day |

*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/Boxed Warnings*

- Contraindication(s): Known hypersensitivity to memantine hydrochloride (Namenda XR/Namzaric), or donepezil hydrochloride/piperidine derivatives (Namzaric), or to any excipients used in the formulation.
- Boxed warning(s): none reported

*Appendix D: General Information*

- Per the 2007 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

| Drug Name | Dosing Regimen | Maximum Dose |
|---|---|---|
| Memantine ER (Namenda XR) | Initial dose 7 mg PO QD, increase by 7 mg per day at one-week intervals | 28 mg/day |
| Memantine/donepezil (Namzaric) | Initial dose 7 mg/10 mg PO QD, increased in 7 mg increments per week | 28 mg/10 mg/day |

## VI. Product Availability

| Drug Name | Availability |
|---|---|
| Memantine ER (Namenda XR) | Capsule: 7 mg, 14 mg, 21 mg, 28 mg<br>Titration pack: 7 x 7 mg, 7 x 14 mg, 7 x 21 mg, 7 x 28 mg |
| Memantine/donepezil (Namzaric) | Capsule: 7 mg/10 mg, 14 mg/10 mg, 21 mg/10 mg, 28 mg/10 mg |

## VII. References

1. Namenda XR Prescribing Information. Irvine, CA: Allergan USA, Inc.; October 2016. Available at: http://www.namendaxr.com/. Accessed May 21, 2019.
2. Namzaric Prescribing Information. Irvine, CA: Allergan USA, Inc.; January 2019. Available at: http://www.namzaric.com/. Accessed May 21, 2019.
3. Aricept Prescribing Information. Woodcliff Lake, NJ: Eisai Inc.; December 2018. Available at http://www.aricept.com/. Accessed May 21, 2019.
4. Trinh NH, Hoblyn J, Mohanty S and Yaffe K. Efficacy of cholinesterase inhibitors in the treatment of neuropsychiatric symptoms and functional impairment in Alzheimer Disease. JAMA 2003;289(2): 210-216.
5. Blacker CV, Greenwood DT, Wesnes KA, et al. Effect of galantamine hydrobromide in chronic fatigue syndrome: a randomized, controlled trial. JAMA 2004;292(10):1195-204.
6. Tariot PN, Farlow MR, Grossberg GT, et al. for the Memantine Study Group. Memantine treatment in patients with moderate to severe Alzheimer Disease already receiving donepezil; a randomized controlled trial. JAMA 2004;291(3):317-324.
7. 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:

http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/alzheimerwatch.pdf. Accessed May 21, 2019.
8. Rabins PV, Blacker D, Rovner BW, et al. Practice guideline for the treatment of patients with Alzheimer's disease and other dementias 2nd edition. 2007. Available online at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/alzheimers.pdf. Accessed May 21, 2019.
9. The American Geriatrics Society. A Guide to Dementia Diagnosis & Treatment. Available at: http://www.americangeriatrics.org/. Accessed June 19, 2015.

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| 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. | 04.09.18 | 08.18 |
| 3Q 2019 annual review: no significant changes; references reviewed and updated. | 05.21.19 | 08.19 |

**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.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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