

Clinical Policy: Pyridostigmine Syrup (Mestinon)

Reference Number: CP.CPA.313

Effective Date: 08.01.16

Last Review Date: 11.24

Line of Business: Commercial

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Pyridostigmine (Mestinon®) is a cholinesterase inhibitor. Prior authorization is required for the oral syrup.

FDA Approved Indication(s)

Mestinon is indicated for the treatment of myasthenia gravis.

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 pyridostigmine syrup and Mestinon syrup are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Myasthenia Gravis (must meet all):

1. Diagnosis of myasthenia gravis;
2. Documentation supports inability to use generic pyridostigmine tablets (e.g., inability to swallow pill due to young age, disease with bulbar involvement);
3. If request is for brand Mestinon syrup, member must use generic pyridostigmine syrup, unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed 1,500 mg per day.

Approval duration: 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND

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criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial.

II. Continued Therapy

A. Myasthenia Gravis (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. If request is for brand Mestinon syrup, member must use generic pyridostigmine syrup, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, new dose does not exceed 1,500 mg per day.

Approval duration: 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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 policy – 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 and may require prior authorization.

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Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
pyridostigmine tablet (Mestinon)	60-1,500 mg/day (average 600 mg/day) PO divided into 5 to 6 doses, spaced to provide maximum relief	1,500 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): mechanical intestinal or urinary obstruction
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Myasthenia gravis	60-1,500 mg/day (average 600 mg/day) PO divided into 5 to 6 doses, spaced to provide maximum relief	1,500 mg/day

VI. Product Availability

Oral syrup: 60 mg/5 mL (473 mL bottle)

VII. References

- Mestinon Prescribing Information. Bridgewater, NJ: Bausch Health US, LLC; December 2020. Available at: <https://www.bauschhealth.com/Portals/25/Pdf/PI/Mestinon-PI.pdf>. Accessed July 19, 2024.
- Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis. Neurology. 2016;87(4): 419-425.
- Narayanaswami P, Sanders DB, Wolfe GI, et al. International consensus guidance for management of myasthenia gravis 2020 update. Neurology. 2021;96(3):114-22.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2020 annual review: no significant changes; references reviewed and updated.	07.22.20	11.20
4Q 2021 annual review: no significant changes; references reviewed and updated.	07.02.21	11.21
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	09.27.21	02.22
4Q 2022 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	08.08.22	11.22
4Q 2023 annual review: no significant changes; references reviewed and updated.	06.27.23	11.23

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2024 annual review: no significant changes; revised policy/criteria section to also include generic pyridostigmine syrup; added redirection to generic for brand requests per formulary status; references reviewed and updated.	07.30.24	11.24

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.

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. Providers referred to in this clinical policy

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are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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