

## Clinical Policy: Pyridostigmine Syrup (Mestinon)

Reference Number: CP.CPA.313

Effective Date: 08.01.16

Last Review Date: 11.19

Line of Business: Commercial

[Revision Log](#)

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

### Description

Pyridostigmine (Mestinon<sup>®</sup>) 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<sup>®</sup> that Mestinon syrup is **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. Dose does not exceed 1,500 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. Myasthenia Gravis (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 1,500 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 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.*

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**

Drug Name	Dosing Regimen	Maximum Dose
Pyridostigmine oral syrup (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

**VI. Product Availability**

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

**VII. References**

1. Mestinon Prescribing Information. Bridgewater, NJ: Bausch Health US, LLC; April 2019. Available at: <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a851795e-b7a8-40c3-9922-5e79d3eb4d92>. Accessed July 30, 2019.
2. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. Available at: <http://www.clinicalpharmacology-ip.com/>. Accessed July 30, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	02.20.18	
4Q 2018 annual review: no significant changes; references reviewed and updated.	08.03.18	11.18
4Q 2019 annual review: no significant changes; references reviewed and updated.	07.30.19	11.19

**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.

## CLINICAL POLICY

### Pyridostigmine Syrup



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 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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