

Commercial/Healthcare Exchange PA Criteria

Effective: March 2004

Prior Authorization: Cholinesterase Inhibitors

Products Affected: Aricept 23/ODT (donepezil), Exelon capsules/patches (rivastigmine), memantine ER tablets, Namenda (memantine hcl), Namenda XR (memantine extended-release), Namzaric (memantine/donepezil), Razadyne (galantamine), Adlarity (donepezil hydrochloride patch)

Medication Description: Reversible acetylcholinesterase (AChE) inhibitors' therapeutic effect in Alzheimer's disease stems mainly from an increase in the concentration of acetylcholine through the reversible inhibition of its hydrolysis by acetylcholinesterase.

Covered Uses:

Aricept: Treatment of dementia of the Alzheimer's type.

Namenda/XR (memantine): Treatment of moderate to severe dementia of the Alzheimer's type.

Namzaric: Treatment of moderate to severe dementia of the Alzheimer's type in patients stabilized on 10 mg of donepezil hydrochloride once daily.

Exelon: Treatment of mild-to-moderate dementia associated with Parkinson's disease (PD), treatment of mild-to-moderate dementia of the Alzheimer's type (AD)

Razadyne/ER: Treatment of mild to moderate dementia of the Alzheimer's type.

Adlarity: Treatment of mild, moderate, and severe dementia of the Alzheimer's type

Exclusion Criteria:

1. Aricept and Adlarity: Patients with known hypersensitivity to donepezil hydrochloride or to piperidine derivatives.
2. Exelon: Patients with: known hypersensitivity to rivastigmine, other carbamate derivatives, or a previous history of application site reaction with rivastigmine transdermal patch suggestive of allergic contact dermatitis, in the absence of negative allergy testing
3. Namzaric: Patients with known hypersensitivity to memantine hydrochloride, donepezil hydrochloride, or piperidine derivatives.
4. Razadyne: Patients with known hypersensitivity to galantamine hydrobromide.

Required Medical Information:

1. Diagnosis [documentation required]
2. Previous medications tried/failed
3. Current therapy regimen

Age Restrictions: Prior authorization is required for patients less than 50 years old.

Prescriber Restrictions: N/A

Coverage Duration: 12 months

Other Criteria:

- A. Patient has a diagnosis of dementia; AND
- B. Patient has a clinically documented diagnosis of the Alzheimer's type; AND

- C. If the request is for Namzaric, patient is stable on 10 mg of donepezil hydrochloride once daily; OR
- D. Patient has a clinically documented diagnosis of Parkinson’s disease - Exelon (rivastigmine) ONLY*.

References:

- 1. Namenda full prescribing information Forest Pharmaceuticals, Inc. St. Louis MO
- 2. Facts & Comparisons online
- 3. Aricept [package insert] Eisai Inc
- 4. Adlarity [package insert] Corium, Inc. Accessed Aug 2022

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	03/2004
2	Update	Moved to updated template Revision History: 3/16, 2/17	All	02/05/2020
3	Update	Covered uses Exclusion criteria	Added covered use for Exelon to align with FDA label: treatment of mild-to-moderate dementia of the Alzheimer's type (AD). Added exclusion criteria to Exelon: a previous history of application site reaction with rivastigmine transdermal patch suggestive of allergic contact dermatitis, in the absence of negative allergy testing	4/28/2020
4	Update	Products Affected Covered Uses	Addition of Adlarity to Products Affected	8/25/2022