



## STEP THERAPY POLICY

- POLICY:** Alzheimer's Disease – Namenda/Namenda XR Step Therapy Policy
- Namenda® (memantine tablets and oral solution – Allergan, generic)
  - Namenda XR® (memantine extended-release capsules – Allergan)

**REVIEW DATE:** 11/12/2025

### INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

## CIGNA NATIONAL FORMULARY COVERAGE:

### OVERVIEW

Memantine tablets, memantine oral solution, and Namenda XR (14, 21, and 28 mg capsules obsolete as of 4/15/2024), N-methyl-D-aspartate (NMDA) receptor antagonists, are indicated for the **treatment of moderate to severe dementia of the Alzheimer's type**.<sup>1,2</sup>

### POLICY STATEMENT

This program has been developed to encourage the use of a Step 1 Product prior to the use of a Step 2 Product. If the Step Therapy rule is not met for a Step 2 Product at the point of service, coverage will be determined by the Step Therapy criteria below. All approvals are provided for 1 year in duration.

**Note:** Generic memantine extended-release capsules are not included in either Step 1 or Step 2 of this program. This policy does not include Namzaric®

(memantine extended-release and donepezil capsules); the *Alzheimer’s Disease Step Therapy* policy, which addresses the acetylcholinesterase inhibitors (ChIs) [donepezil, rivastigmine, galantamine], includes Namzaric.

**Step 1:** generic memantine tablets, generic memantine oral solution

**Step 2:** Namenda tablets, Namenda oral solution, Namenda XR

***Alzheimer’s Disease – Namenda/Namenda XR Step Therapy Policy* product(s) is(are) covered as medically necessary when the following step therapy criteria is(are) met. Any other exception is considered not medically necessary.**

**CRITERIA**

1. If the patient has tried one Step 1 Product, approve a Step 2 Product.

**REFERENCES**

1. Namenda® tablets and oral solution [prescribing information]. Madison, NJ: Allergan; November 2018.
2. Memantine hydrochloride extended-release capsules [prescribing information]. Bridgewater, NJ: Amneal; July 2024.
3. Namzaric® capsules [prescribing information]. North Chicago, IL: AbbVie; May 2024.

**HISTORY**

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	12/06/2023
Annual Revision	No criteria changes.	12/04/2024
Annual Revision	<b>Policy Name:</b> Updated policy name to begin with “Alzheimer’s Disease” instead of “Alzheimer’s”. No criteria changes.	11/12/2025

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