

<b>Clinical Policy Title:</b>	mecamylamine
<b>Policy Number:</b>	RxA.540
<b>Drug(s) Applied:</b>	Vecamyl®
<b>Original Policy Date:</b>	03/06/2020
<b>Last Review Date:</b>	12/11/2025
<b>Line of Business Policy Applies to:</b>	All lines of business (except Medicare)

## Criteria

### I. Initial Approval Criteria

#### A. Hypertension (must meet all):

1. Diagnosis of hypertension;
2. Trial and failure of a combination of 3 formulary antihypertensive agents from different classes, unless contraindicated or clinically significant adverse effects are experienced.

#### Approval Duration

**All Lines of Business (except Medicare):** 6 months

### II. Continued Therapy Approval

#### A. Hypertension (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

#### Approval Duration

**All Lines of Business (except Medicare):** 12 months

## References

Not Applicable

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed: <ol style="list-style-type: none"> <li>1. Clinical policy title was updated.</li> <li>2. Lines of business policy applies to was updated to all lines of business.</li> <li>3. Continued therapy approval criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...".</li> <li>4. References were reviewed and updated.</li> </ol>	09/12/2020	12/07/2020
Policy was reviewed:	09/25/2021	12/07/2021

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

1. References were reviewed and updated.		
Policy was reviewed: 1. Initial Approval Criteria I.A.3: Updated to remove phrase 'at maximally indicated doses'. 2. References were reviewed and updated	09/13/2022	10/19/2022
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed age restrictions. 2. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 3. Removed reauthorization requirement for positive response to therapy. 4. Updated approval duration verbiage.	8/28/2024	9/13/2024
Policy was reviewed.	12/05/2024	N/A
Policy reviewed.	12/11/2025	12/11/2025