

Clinical Policy: Mecamylamine (Vecamyl)

Reference Number: CP.PMN.136

Effective Date: 05.01.17

Last Review Date: 05.19

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Mecamylamine (Vecamyl[®]) is an oral anti-hypertension agent and ganglion blocker.

FDA Approved Indication(s)

Vecamyl is indicated for the management of moderately severe to severe essential hypertension and in uncomplicated cases of malignant hypertension.

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 Vecamyl is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hypertension (must meet all):

1. Diagnosis of hypertension;
2. Failure of a combination of 3 formulary antihypertensive agents (*see Appendix D for rationale*) from different classes, at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
3. Age \geq 18 years.

Approval duration:

Medicaid/HIM – 6 months

Commercial – 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, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Hypertension (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.

Approval duration:

Medicaid/HIM – 12 months
Commercial – 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, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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 policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid 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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Angiotensin-converting enzyme (ACE) inhibitors (e.g., lisinopril, enalapril, benazepril)	Refer to the prescribing information	Refer to the prescribing information
Angiotensin II receptor blockers (ARBs; e.g., losartan, valsartan, candesartan)	Refer to the prescribing information	Refer to the prescribing information
Thiazide diuretics (e.g., hydrochlorothiazide)	Refer to the prescribing information	Refer to the prescribing information
Calcium channel blockers (e.g., amlodipine, diltiazem, verapamil)	Refer to the prescribing information	Refer to the prescribing information
Beta blockers (e.g., carvediolol, metoprolol, nebivolol)	Refer to the prescribing information	Refer to the prescribing information
Alpha blockers (e.g., prazosin, terazosin, doxazosin)	Refer to the prescribing information	Refer to the prescribing information

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): Concomitant antibiotics or sulfonamides, coronary insufficiency, glaucoma, mild or moderate hypertension, organic pyloric stenosis, recent myocardial infarction, renal insufficiency, uremia, and hypersensitivity to mecamylamine.
- Boxed warning(s): none reported

Appendix D: General Information

- Rationale for combination of 3 formulary antihypertensive agents: The recognition that triple-combination therapy is frequently a necessity is based on large-scale studies.
 - In the Study on Cognition and Prognosis in the Elderly (SCOPE) of 4,964 elderly patients with stage 2 hypertension (BP: 160–179/90–99 mm Hg), 49% of patients were receiving ≥ 3 antihypertensive agents by the end of the study.
 - Similarly, in the International Verapamil SR and Trandolapril Study (INVEST) involving patients with hypertension (mean BP: 150/86 mm Hg) and coronary artery disease, about half of the patients assigned to receive a CCB or a b-blocker were receiving ≥ 3 antihypertensive medications at the end of the 2-year follow-up period.²⁰
 - In ALLHAT, ≥ 3 antihypertensive agents were necessary for 24% of black patients and 24% of nonblack patients initially assigned to receive chlorthalidone, for 41% and 31%, respectively, initially assigned to receive lisinopril, and for 28% and 25%, respectively, of those initially assigned to receive amlodipine.
 - At study end point in ACCOMPLISH, 32% of the 11,506 patients with hypertension at high risk for CV disease were receiving at least 1 other antihypertensive agent in addition to initial therapy with either benazepril/amlodipine or benazepril/HCTZ.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Hypertension	Initiate therapy with 2.5 mg PO BID. Titrate in increments of 2.5 mg at intervals of not less than 2 days until desire blood pressure response occurs.	Based on individual response

VI. Product Availability

Tablet: 2.5 mg

VII. References

1. Vecamyl Prescribing Information. Colorado Springs, Co: Nexgen Pharma; April 2015. Available at: www.vecamyl.com. Accessed February 5, 2019.
2. James PA, Oparil S, Carter BL, et al. 2014 evidence-based guideline for the management of high blood pressure in adults: report from the panel members appointed to the Eighth Joint National Committee (JNC 8). JAMA. 2014 Feb 5;311(5):507-20. doi: 10.1001/jama.2013.284427.
3. Chobanian AV, Bakris GL, Black HR, et al. Seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. Hypertension. 2003 Dec;42(6):1206-52. Epub 2003 Dec 1.
4. Gradman, AH. Rationale for triple-combination therapy for management of high blood pressure. J Clin Hypertens 2010; 12:869-878. doi: 10.1111/j.1751-7176.2010.00360.x

Reviews, Revisions, and Approvals	Date	P&T Approval Date
HIM: Policy created.	02.17	05.17
2Q 2018 annual review: no significant changes; replaces HIM.PA.111; added Medicaid and commercial; added age; reviewed and updated.	02.08.18	05.18
2Q 2019 annual review: no significant changes; added contraindications; references reviewed and updated.	02.05.19	05.19

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.

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.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy; HIM.PA.103.

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