



## Pharmacy Benefit Coverage Criteria

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Coverage Policy Number ..... P0107

# Pyridostigmine

## Table of Contents

Medical Necessity Criteria .....	1
FDA Approved Indications .....	2
Recommended Dosing .....	2
Background.....	2
References .....	2

## Related Coverage Resources

[Quantity Limitations](#)

### 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. 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.

## Medical Necessity Criteria

**Pyridostigmine 30mg tablets are considered medically necessary when ALL of the following criteria is met:**

- Treatment of myasthenia gravis
- Documented inability to use pyridostigmine 60 mg tablets (a scored tablet).

**Initial authorization is up to 12 months.**

**Pyridostigmine 30mg tablets are considered medically necessary for continued use when ALL of the following are met:**

- Individual continues to meet the initial criteria
- Attestation of beneficial clinical response

**Reauthorization for up to 12 months.**

**When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy. Pyridostigmine 30mg tablets are considered experimental, investigational or unproven for ANY other use.**

**Note: Receipt of sample product does not satisfy any criteria requirements for coverage.**

\*If you're a Cigna provider, please [log in to the Cigna for Health Care Professionals](#) website and search for specific patients to view their covered medications.

## FDA Approved Indications

### FDA Approved Indication

Pyridostigmine is indicated for the treatment of myasthenia gravis and pretreatment for Soman nerve gas exposure (military use only).

## Recommended Dosing

### FDA Recommended Dosing

60 to 1,500 mg/day, usually 600 mg/day divided into 5 to 6 doses, spaced to provide maximum relief.

### Drug Availability

Pyridostigmine is available in 30 mg and 60 mg immediate-release tablets.

## Background

### Therapeutic Alternatives

Therapeutic alternatives to pyridostigmine 30 mg include the following drugs: Pyridostigmine 60 mg immediate-release functionally scored tablets.

### Professional Societies/Organizations

The American Academy of Neurology (AAN), International Consensus Guidance for Management of Myasthenia Gravis (MG), states that pyridostigmine should be part of the initial treatment in most individuals with MG. Corticosteroids or immunosuppressive therapy should be used in all individuals with MG who have not met treatment goals after an adequate trial of pyridostigmine. (Sanders, 2016)

### Off Label Uses

AHFS Drug Information 2019 Edition does not support any off-label uses of pyridostigmine.

### Comparative Studies

There are no clinical studies comparing pyridostigmine with other therapeutic alternatives.

## References

1. Pyridostigmine bromide tablets, 30 mg [product information]. Montreal, Quebec, Canada: ICN Canada Limited. July 2019
2. McEvoy GK, Pharm.D., ed. 2019. AHFS Drug Information® - 59th Ed. Bethesda, MD. American Society of Health-System Pharmacists.
3. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis: Executive summary. *Neurology*. 2016 Jul 26; 87(4):419-25.

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