UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Anthelmintics

Program	Prior Authorization
Medication	Albenza (albendazole), Emverm (mebendazole), Vermox (mebendazole)
Markets in Scope	Hawaii, Maryland, New Jersey, New York, New York EPP, Pennsylvania- CHIP, Rhode Island, California, Nevada, South Carolina
Issue Date	2/2017
Pharmacy and Therapeutics Approval Date	4/2020
Effective Date	6/2020

1. Background:

Albenza is indicated for the treatment of parenchymal neurocysticercosis due to active lesions caused by larval forms of the pork tapeworm, *Taenia solium*. Albenza is also indicated for the treatment of cystic hydatid disease of the liver, lung, and peritoneum, caused by the larval form of the dog tapeworm, *Echinococcus granulosus*.

Emverm is indicated for the treatment of *Enterobius vermicularis* (pinworm), *Trichuris trichiura* (whipworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), and *Necator americanus* (American hookworm) in single or mixed infections.

Vermox is indicated for the treatment of patients one year of age and older with gastrointestinal infections caused by *Trichuris trichiura* (whipworm) and *Ascaris lumbricoides* (roundworm).

CDC guidelines recommend use in several other parasitic infections.

2. Coverage Criteria:

A. *Enterobius vermicularis* (pinworm)

1. **Albenza, Emverm or Vermox** will be approved based on **all** of the following:

   a. Diagnsosis of *Enterobius vermicularis* (pinworm)

   -AND-

   b. History of failure, contraindication or intolerance to over-the-counter pyrantel pamoate

   Authorization will be issued for one month.

B. *Taenia solium* (Neurocysticercosis)

1. **Albenza** will be approved based on the following criterion:

    a. Diagnosis of Neurocysticercosis

    Authorization will be issued for six months.

C. Echinococcosis (Tapeworm)

1. **Albenza, Emverm or Vermox** will be approved based on the following criterion:

    a. Diagnosis of Hydatid Disease [Echinococcosis (Tapeworm)]

    Authorization will be issued for six months.

D. Ancylostoma/Necatoriasis (Hookworm)

1. **Albenza, Emverm or Vermox** will be approved based on the following criterion:

    a. Diagnosis of Ancylostoma/Necatoriasis (Hookworm)

    Authorization will be issued for one month.

E. Ascariasis (Roundworm)

1. **Albenza, Emverm or Vermox** will be approved based on the following criterion:

    a. Diagnosis of Ascariasis (Roundworm)

    Authorization will be issued for one month.

F. Toxocariasis (Roundworm)

1. **Albenza, Emverm or Vermox** will be approved based on the following criterion:

    a. Diagnosis of Toxocariasis (Roundworm)

    Authorization will be issued for one month.

G. Trichinellosis

1. **Albenza, Emverm or Vermox** will be approved based on the following criterion:

    a. Diagnosis of Trichinellosis

    Authorization will be issued for one month.

H. Trichuriasis (Whipworm)

1. **Albenza, Emverm or Vermox** will be approved based on the following criterion:

    a. Diagnosis of Trichuriasis (Whipworm)

    Authorization will be issued for one month.

I. Capillariasis

1. **Albenza, Emverm, or Vermox will be approved based on the following criterion:**

    a. Diagnosis of Capillariasis.

    Authorization will be issued for one month.

J. Baylisascaris

1. **Albenza, Emverm, or Vermox** will be approved based on the following criterion**:**

    a. Diagnosis of Baylisascaris

    Authorization will be issued for one month.

K. Clonorchiasis (Liver flukes)

1. **Albenza** will be approved based on the following criterion**:**

    a. Diagnosis of Clonorchiasis

    Authorization will be issued for one month.

L. Gnathostomiasis

1. **Albenza** will be approved based on the following criterion**:**

    a. Diagnosis of Gnathostomiasis

    Authorization will be issued for one month.

M. Strongyloidiasis

1. **Albenza** will be approved based on the following criterion**:**

    a. Diagnosis of Strongyloidiasis

    Authorization will be issued for one month.

N. Loiasis

1. **Albenza** will be approved based on the following criterion:
    a. Diagnosis of Loiasis

Authorization will be issued for one month.

O. Opisthorchis

1. **Albenza** will be approved based on the following criterion:

    a. Diagnosis of Opisthorchis

Authorization will be issued for one month.

Compendia of current literature: • American Hospital Formulary Service Drug Information • National Comprehensive Cancer Network Drugs and Biologics Compendium • Thomson Micromedex DrugDex • Clinical Pharmacology • United States Pharmacopoeia-National Formulary (USP-NF)

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. CDC treatment guidelines. http://www.cdc.gov./parasites (accessed 3/4/2020).
2. Albenza [prescribing information]. Horsham, PA: Amedra Pharmaceuticals LLC; 2018.
3. Emverm [prescribing information]. Horsham, PA: Amedra Pharmaceuticals LLC; 2019.
4. Vermox [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals, Inc; 2019.

Program	Prior Authorization – Anthelmintics
Change Control	
2/2017	New program.
3/2017	Updated background. Clarified "All Other Indications" section by adding that medication must be for an FDA-approved indication, supported by information from the appropriate compendia of current literature, or CDC treatment guidelines.
4/2017	Incorporated CDC and FDA labeled indications. Updated authorization time based on CDC and FDA recommendations.
6/2017	Added Albenza as an approvable drug for *Mansonella perstans* (Filariasis).
6/2018	Annual review. Updated references.
5/2019	Annual review. Added Albenza as an approvable drug for

	Clonorchiasis, Gnathostomiasis, Strongyloidiasis per CDC treatment guidelines. Removed Albenza as an approvable drug for *Mansonella perstans* per CDC treatment guidelines. Updated references.
4/2020	Annual review. Added Albenza for *Loa loa, Opisthorchis* per CDC guidelines. Removed Emverm and Vermox for *Mansonella perstans*.