UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2018 P 2114-4
Program	Prior Authorization – Medical Necessity
Medication	Albenza (albendazole), Emverm (mebendazole), Vermox (mebendazole)
P&T Approval Date	11/2016, 3/2017, 6/2017, 6/2018
Effective Date	9/1/2018; Oxford only: 9/1/2018

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]:

A. *Enterobius vermicularis* (pinworm)

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

   a. Diagnosis 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. *Mansonella perstans* (Filariasis)

1. **Albenza, Emverm or Vermox** will be approved based on the following criterion:
    a. Diagnosis of *Mansonella perstans* (Filariasis)

Authorization will be issued for one month.

G. *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.

H. *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.

I. *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.

J. *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.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:
N/A

4. References:

1. CDC treatment guidelines. http://www.cdc.gov.
2. Albenza [prescribing information]. Amedra Pharmaceuticals LLC. Horsham, PA. December 2017.
3. Emverm [prescribing information]. Amedra Pharmaceuticals LLC. Horsham, PA. December 2015.
4. Vermox [prescribing information]. Janssen Pharmaceuticals, Inc. Titusville, NJ. October 2016.

Program	Prior Authorization – Medical Necessity – Anthelmintics
Change Control	
11/2016	New program.
3/2017	Updated background. 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). State mandate reference language updated.
6/2018	Annual review. References updated.