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. 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. **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.**

K. 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.**

L. Clonorchiasis (Liver flukes)

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

   **Authorization will be issued for one month.**

M. Gnathostomiasis

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

   **Authorization will be issued for one month.**

N. Strongyloidiasis

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

   **Authorization will be issued for one month.**

* 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:**
   - 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:**

<table>
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<tr>
<th>Program</th>
<th>Prior Authorization – Medical Necessity – Anthelmintics</th>
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<tr>
<td><strong>Change Control</strong></td>
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<tr>
<td>11/2016</td>
<td>New program.</td>
</tr>
<tr>
<td>3/2017</td>
<td>Updated background. Incorporated CDC and FDA labeled indications. Updated authorization time based on CDC and FDA recommendations.</td>
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