UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2021 P 2114-7
Program	Prior Authorization – Medical Necessity
Medication	Albenza (albendazole), Emverm (mebendazole)
P&T Approval Date	11/2016, 3/2017, 6/2017, 6/2018, 5/2019, 4/2020, 5/2021
Effective Date	8/1/2021; Oxford only: 8/1/2021

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.

CDC guidelines recommend use in several other parasitic infections.

2. Coverage Criteria[a]:

A. *Enterobius vermicularis* (pinworm)

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

   a. Diagnosis of Toxocariasis (Roundworm)

Authorization will be issued for one month.

G. Trichinellosis

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

   a. Diagnosis of Trichinellosis

Authorization will be issued for one month.

H. Trichuriasis (Whipworm)

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

   a. Diagnosis of Trichuriasis (Whipworm)

Authorization will be issued for one month.

I. Capillariasis

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

   a. Diagnosis of Capillariasis

Authorization will be issued for one month.

J. Baylisascaris

1. **Albenza or Emverm** 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.

[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:

- 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 4/1/2021).
2. Albenza [package insert]. Horsham, PA: Amedra Pharmaceuticals LLC; July2019.
3. Emverm [package insert]. Horsham, PA: Amedra Pharmaceuticals LLC; January 2019.

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.
5/2019	Annual review. Added Albenza for *Clonorchiasis*, *Gnathostomiasis*, *Strongyloidiasis* per CDC treatment guidelines. Removed Albenza 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*.
5/2021	Annual review. Removed Vermox from program due to product discontinuation. Updated references.