Effective Date: 11/01/2021
Reviewed: 09/2021 Scope: Medicaid, Commercial

Ivermectin

POLICY

I. CRITERIA FOR APPROVAL

An authorization of one month may be granted when the following criteria is met:

Ivermectin oral tablet will be approved for patients with a diagnosis of one of the following:

A. Intestinal strongyloidiasis due to the nematode parasite Strongyloides stercoralis
B. Onchocerciasis due to the nematode parasite Onchocerca volvulus
C. Ascariasis due to Ascaris lumbricoides (off-label use)
D. Demodicosis due to Demodex folliculorum and Demodex brevis (off-label use)
E. Gnathostomiasis due to Gnathostoma spinigerum (off-label use)
F. Lice (off-label use)
G. Mansonella ozzardi infection (off-label use)
H. Mansonella streptocerca infection (off-label use)
I. Scabies due to Sarcoptes scabiei (off-label use)
J. Trichuriasis due to Trichuris trichiura (off-label use)
K. Wucheria bancrofti infection (off-label use)
L. Cutaneous larva migrans (off-label use)
M. Dermatosis due to mites (off-label use)
N. Enterobiasis (off-label use)
O. Infection by Loa loa (off-label use)
P. Infection by Phthirus pubis (off-label use)

II. COVERAGE DURATION

- 1 month

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