



Ivermectin Prior Authorization

Drug Applied:	ivermectin
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Criteria:

Drug Applied will be approved when all of the following criteria are met:

I. Initial Therapy Criteria

A. **FDA-approved indication** as indicated by chart notes within past 90 days

1. ONE of the following diagnoses:

- a) Strongyloidiasis due to *Strongyloides stercoralis* **or**
- b) Onchocerciasis due to *Onchocerca volvulus*

Approval Duration: 1 month

B. **Other-supported indication** as indicated by chart notes within past 90 days

1. ONE of the following:

- a) Patient has scabies or lice and has failed topical permethrin **or**
- b) Patient has demodex blepharitis **or**
- c) Patient has another compendia-supported indication

Approval Duration: 1 month

Policy Owned by: Curative PBM team