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.**

   *For Maryland, requests for continuation of therapy may also be approved if the provider confirms the patient has been on the medication in the past 180 days and that the medication is effective in treating the patient’s condition. Please see Maryland continuation of care guideline.*

   *For Indiana (effective 7/1/16) and West Virginia (effective 1/1/17), step therapy requirements may be approved if the patient has previously received either a documented step one prescription drug or another prescription drug that has the same mechanism of action as a preceding prescription drug, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event. For West Virginia (effective 1/1/17) members only, coverage may also be provided for continuation of therapy if the member is currently stabilized on the requested medication for the same medical condition.*

   *For California, requests for continuation of therapy may also be approved if the provider confirms the patient has been on the medication, it is appropriately prescribed, and that the medication is considered safe and effective in treating the patient’s condition.*

3. **Additional Clinical Rules:**
   
   N/A

4. **References:**
   
<table>
<thead>
<tr>
<th>Program</th>
<th>Prior Authorization – Medical Necessity – Anthelmintics</th>
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<tr>
<td></td>
<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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