Effective Date **12/15/2023**
Next Review Date… **12/15/2024**
Coverage Policy Number **IP0300**

Ivermectin

Table of Contents

Related Coverage Resources

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This policy supports medical necessity review for ivermectin (**Stromectol®**) tablets.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Medical Necessity Criteria

Ivermectin (Stromectol) is considered medically necessary when ONE of the following is met:

1. **Onchocerciasis Infection.** Individual meets the following criteria:
   A. Documented diagnosis of Onchocerciasis Infection

2. **Strongyloidiasis.** Individual meets the following criteria:
   A. Documented diagnosis of Strongyloidiasis

3. **Ascariasis.** Individual meets the following criteria:

A. Documented diagnosis of Ascariasis

4. ***Demodex folliculorum* infection.** Individual meets the following criteria:
   A. Documented diagnosis of *Demodex folliculorum* infection

5. **Enterobiasis (pinworm infection).** Individual meets the following criteria:
   A. Documented diagnosis of Enterobiasis (pinworm infection)

6. **Gnathostomiasis.** Individual meets the following criteria:
   A. Documented diagnosis of Gnathostomiasis

7. **Hookworm-related cutaneous larva migrans.** Individual meets the following criteria:
   A. Documented diagnosis of Hookworm-related cutaneous larva migrans

8. ***Mansonella ozzardi* infection.** Individual meets the following criteria:
   A. Documented diagnosis of *Mansonella ozzardi* infection

9. ***Mansonella streptocerca* infection.** Individual meets the following criteria:
   A. Documented diagnosis of *Mansonella streptocerca* infection

10. **Pediculosis.** Individual meets the following criteria:
    A. Documented diagnosis of Pediculosis

11. **Scabies.** Individual meets the following criteria:
    A. Documented diagnosis of **ONE** of the following:
       i. Classic scabies
       ii. Treatment-resistant scabies
       iii. Unable to tolerate topical treatment
       iv. Crusted scabies (i.e., Norwegian scabies)
       v. Prevention and/or control of scabies

12. **Trichuriasis.** Individual meets the following criteria:
    A. Documented diagnosis of Trichuriasis

13. ***Wuchereria bancrofti* infection.** Individual meets the following criteria:
    A. Documented diagnosis of *Wuchereria bancrofti* infection

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When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Reauthorization Criteria

Not applicable for continuation beyond initial approval duration.

Authorization Duration

Initial approval duration:
1. Onchocerciasis Infection: Approve for one dose.
2. Strongyloidiasis: Approve for two doses.
3. Ascariasis: Approve for one dose.
4. *Demodex folliculorum* infection: Approve for two doses.
5. Enterobiasis (pinworm infection): Approve for two doses.

6. Gnathostomiasis: Approve for one dose.
7. Hookworm-related cutaneous larva migrans: Approve for one dose.
8. *Mansonella ozzardi* infection: Approve for one dose.
9. *Mansonella streptocerca* infection: Approve for one dose.
10. Pediculosis: Approve for three doses.
11. Scabies: Approve for the duration noted below
    A. Classic scabies: Approve for two doses.
    B. Treatment-resistant scabies: Approve for two doses.
    C. Unable to tolerate topical treatment: Approve for two doses.
    D. Crusted scabies (i.e., Norwegian scabies): Approve for five doses.
    E. Prevention and/or control of scabies: Approve one dose.
12. Trichuriasis: Approve for three doses.
13. *Wuchereria bancrofti* infection: Approve for one dose.

Reauthorization approval duration: not applicable

Conditions Not Covered

Any other use is considered experimental, investigational or unproven, including the following (this list may not be all inclusive):

> **Coronavirus disease 2019 (COVID-19).** The CDC's COVID-19 Treatment Guideline Panel reviewed studies that assessed the efficacy of oral ivermectin in the treatment of COVID-19.[17] The panel reviewed data from several clinical trials and cited the following findings: oral ivermectin did not reduce the need for emergency setting visits or hospitalizations when compared with placebo; there was no evidence of virologic or clinical benefit of using oral ivermectin; there was no evidence that oral ivermectin reduced progression to severe disease, improve time to resolution of symptoms; and compared with standard of care, oral ivermectin did not result in differences in all-cause mortality, hospital length of stay, or the need for mechanical ventilation. The Panel recommends **against** the use of ivermectin for the treatment of COVID-19, except in clinical trials.

Background

OVERVIEW
Ivermectin tablets (Stromectol, generic), an anthelmintic, are indicated for the treatment of intestinal (i.e., non-disseminated) **strongyloidiasis** due to the nematode parasite *Strongyloides stercoralis* and for the treatment of **onchocerciasis** due to the nematode parasite *Onchocerca volvulus*.[1] Ivermectin tablets do not have any activity against adult *O. volvulus* parasites and surgical excision of *O. volvulus* nodules is the recommended treatment.

The prescribing information notes that ivermectin tablets are given as a single oral dose for these two indications.[1] However, other sources note that ivermectin tablets should be given for 2 days for the treatment of strongyloidiasis.[1-3]

Off-Label Uses
Ivermectin has been used for many parasitic infections (off-label).[2,3,6] The Centers for Disease Control and Prevention (CDC) notes ivermectin tablets as a treatment option for the following: ascariasis, gnathostomiasis, hookworm-related cutaneous larva migrans, pediculosis (*pediculus humanus capitis*, *pediculus humanus corporis*, and pediculosis pubis [due to *Phthirus pubis*]), scabies, trichuriasis, and *Wucheria bancrofti* infection (a main cause of lymphatic filariasis).[7-15] There are data to support the use of ivermectin tablets for the treatment of enterobiasis, *Demodex folliculorum*, and *Mansonella ozzardi* and *M. streptocerca* infections.[6,16]

References

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