Effective Date **1/1/2023**
Next Review Date… **1/1/2024**
Coverage Policy Number **IP0462**

Albendazole for Individual and Family Plans

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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 albendazole tablets on Individual and Family Plans.

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

Medical Necessity Criteria

Albendazole is considered medically necessary when BOTH of the following are met (1 and 2):

1. For the treatment of **ANY** of the following infections documented by clinical findings and appropriate lab confirmation:
    A. **Ascariasis.**
    B. ***Clonorchis sinensis* or *Opisthorchis viverrini* Infection.**
    C. ***Cutaneous larva migrans.***
    D. **Cystic hydatid disease due to *Echinococcus granulosus.***
    E. **Enterobiasis.**

F. **Eosinophilic enterocolitis caused by *Ancylostoma caninum.***
G. **Giardiasis caused by *Giardia duodenalis.***
H. **Gnathostomiasis caused by *Gnathostoma spinigerum.***
I. **Gongylonemiasis caused by *Gongylonema spp.***
J. **Hookworm Infection.**
K. **Microsporidiosis.**
L. **Neurocysticercosis.**
M. ***Oesophagostomum bifurcum* Infection.**
N. **Trichinellosis caused by *Trichinella spiralis* or other *Trichinella spp.***
O. **Toxocariasis.**

2. Prescribed by or in consultation with an infectious disease or tropical disease specialist.

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:
- Hydatid Disease: up to 6 months
- All other indications: up to 1 month

Reauthorization approval duration: Not applicable

Conditions Not Covered

Any other use is considered experimental, investigational or unproven.

Background

OVERVIEW
Antiparasitic agents are used in the treatment of various parasitic infections. Drug selection, dose, and duration for treatment and/or prophylaxis are dependent upon the parasite.

Albendazole is an anthelmintic agent indicated for the treatment of the following infections:[1,2]
1. **Hydatid Disease:** Treatment of Cystic hydatid disease of the liver, lung, and peritoneum, caused by the larval form of the dog tapeworm, *Echinococcus granulosus.*
2. **Neurocysticercosis:** Treatment of parenchymal neurocysticercosis due to active lesions caused by larval forms of the pork tapeworm, *Taenia solium.*

Off-label Uses[2,3]
Albendazole can also be used in treating the following parasitic infections: *Ancylostoma caninum*, *Ancylostoma duodenale, Necator americanus,* Ascariasis, *Clonorchis sinensis, Opisthorchis viverrini, Cutaneous larva migrans,* Enterobiasis, Giardiasis, Gnathostomiasis, Gongylonemiasis, Microsporidiosis, *Oesophagostomum bifurcum*, Toxocariasis, Trichinellosis.

Dosing
The dose of albendazole is based on the indication (Table 1).[1] Albendazole is supplied in 200 mg tablets which may be crushed or chewed.[1]

Table 1. Dosing.[1]

Indication	Patient Weight	Dose	Duration
Hydatid Disease	≥ 60 kg	400 mg BID with meals	28-day cycle followed by a 14-day albendazole-free interval, for a total of 3 cycles
	< 60 kg	15 mg/kg/day given in divided doses twice daily with meals (maximum total daily dose 800 mg)	
Neurocysticercosis	≥ 60 kg	400 mg BID with meals	8 to 30 days
	< 60 kg	15 mg/kg/day given in divided doses twice daily with meals (maximum total daily dose 800 mg)	

References

1. Albenza® tablets [prescribing information]. Hayward, CA: Impax; July 2019.
2. Albendazole Oral. Drug Facts and Comparisons. Facts & Comparisons eAnswers. Wolters Kluwer Health, Inc. Riverwoods, IL. Accessed July 6, 2022. http://online.factsandcomparisons.com
3. Albendazole. [AHFS Drug Information]. AHFS Clinical Drug Information. Bethesda, MD: American Society of Health-System Pharmacists, Inc. Updated June 3, 2019. Accessed July 7, 2022.