Health Alliance™

Pharmacy Drug Policy & Procedure

Policy Name:	Ivermectin	Policy #:	3053P

Purpose of the Policy

The purpose of this policy is to establish prior authorization criteria for ivermectin.

Statement of the Policy

Health Alliance Medical Plans will approve the use of ivermectin when the criteria below have been met.

Criteria

1. Coverage Criteria

1.1 All FDA-approved indications

2. Approval Period

2.1 12 months

3. Exclusion Criteria

3.1 Used for the treatment of COVID-19

CPT Codes

HCPCS Codes

References

1. Ivermectin tablets [prescribing information]. Parsippany, NJ: Edenbridge Pharmaceuticals, LLC; March 2022.

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DISCLAIMER
This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not

intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-8513379 for verification of coverage.