Drug Coverage Policy

Effective Date.....5/15/2025
Coverage Policy Number.....IP0300
Policy Title.....Ivermectin Tablets

Infectious Disease – Ivermectin Tablets

- Stromectol® (ivermectin tablets – Merck, generic)

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. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. 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
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*, *Mansonella ozzardi* and *M. streptocerca* infections.[6,16]

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POLICY STATEMENT
Prior Authorization is required for prescription benefit coverage of ivermectin tablets. All approvals are provided for 1 month (30 days), which is an adequate duration of time for the patient to receive the required number of doses.

Ivermectin tablets are considered medically necessary when BOTH of the following are met:

1. **ONE** of the following:

   FDA-Approved Indications

   A. Onchocerciasis Infection. Approve for one month.
   B. Strongyloidiasis. Approve for one month.

   Other Uses with Supportive Evidence

   C. Ascariasis. Approve for one month.
   D. *Demodex folliculorum* infection. Approve for one month.
   E. Enterobiasis (pinworm infection). Approve for one month.
   F. Gnathostomiasis. Approve for one month.
   G. Hookworm-related cutaneous larva migrans. Approve for one month.
   H. *Mansonella ozzardi* infection. Approve for one month.
   I. *Mansonella streptocerca* infection. Approve for one month.
   J. Pediculosis. Approve for one month if the patient meets one of the following (i, ii, or iii):
      i. Patient has infection caused by *pediculus humanus capitis* (head lice); OR
      ii. Patient has infection caused by *pediculus humanus corporis* (body lice); OR
      iii. Patient has pediculosis pubis caused by *Phthirus pubis* (pubic lice).
   K. Scabies. Approve for one month if the patient meets one of the following (i, ii, iii, iv, or v):
      i. Patient has classic scabies; OR
      ii. Patient has treatment-resistant scabies; OR
      iii. Patient is unable to tolerate topical treatment; OR
      iv. Patient has crusted scabies (i.e., Norwegian scabies); OR
      v. Patient is using ivermectin tablets for prevention and/or control of scabies.
   L. Trichuriasis. Approve for one month.
   M. *Wucheria bancrofti* infection. Approve for one month.

2. For Individual and Family Plans, preferred product criteria is met for the products listed in the below table(s)

Individual and Family Plans:

Product	Criteria
Stromectol 3mg tablets (ivermectin tablets)	Trial of the bioequivalent generic product, **ivermectin 3mg tablets** AND cannot take due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which would result, per the prescriber, in a significant allergy or serious adverse reaction.

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.

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

Ivermectin tablets for any other use is considered not medically necessary , including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Coronavirus disease 2019 (COVID-19).** The Infectious Disease Society of America (IDSA) guidelines on the treatment of management of patients with COVID-19 (updated 2022) reviewed studies that assessed the efficacy of oral ivermectin in the treatment of COVID-19.[17] The IDSA reviewed data from several clinical trials and cited the following findings: oral ivermectin did not reduce mortality; failed to demonstrate a beneficial or detrimental effect on symptoms, hospitalization or viral clearance; 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 IDSA recommends **against** the use of ivermectin for the treatment of COVID-19, except in clinical trials.

References

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16. Ta-Ting TH, Crainey JL, Post RJ, et al. Mansonellosis: current perspectives. *Res Rep Trop Med*. 2018;9:9-24.
17. Bhimraj A, Morgan RL, Nadig N, et al. IDSA guidelines on the treatment and management of patients with COVID-19. *Clin Infect Dis.* 2024;78(7):e250-e349.

References

Type of Revision	Summary of Changes	Date
Annual Review	**For all covered conditions**: (1) Removed requirement of 'documented diagnosis of…' respective of each covered condition (2) The number of approvable doses was removed. All approval durations are listed for one month. **For Pediculosis**: Added (1) Patient has infection caused by pediculus humanus capitis (head lice); (2) Patient has infection caused by pediculus humanus corporis (body lice); OR (3) Patient has pediculosis pubis caused by Phthirus pubis (pubic lice). **For IFP PPRC**: Added Stromectol	6/1/2024
Annual Revision	No criteria changes.	5/15/2025

The policy effective date is in force until updated or retired.