

Market Applicability						
Market	GA	KY	MD	NJ	NY	WA
Applicable	X	X	X	X	X	NA

Soolantra (ivermectin)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

Medications	Quantity Limit
Soolantra (ivermectin) 1% cream	May be subject to quantity limit

APPROVAL CRITERIA

If the benefit requires prior authorization, requests for Soolantra (ivermectin) may be approved for the following:

- I. Individual is 18 years of age or older; **AND**
- II. Individual is using for the treatment of inflammatory lesions associated with moderate or severe rosacea; **AND**
- III. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to one preferred generic topical metronidazole agent;

Preferred generic topical metronidazole agents: Metronidazole topical 0.75% gel, metronidazole 0.75% cream, metronidazole 0.75% lotion, rosadan 0.75% gel, rosadan 0.75% cream

OR

- IV. Individual has a known topical metronidazole contraindication.

Key References:

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2020. URL: <http://www.clinicalpharmacology.com>. Updated periodically.
2. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. <http://dailymed.nlm.nih.gov/dailymed/about.cfm>.
3. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
4. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2020; Updated periodically.

Federal and state laws or requirements, contract language, and Plan utilization management programs or policies may take precedence over the application of this clinical criteria.

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CRX-ALL-0613-20

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

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