Clinical Policy: Ivermectin (Soolantra)

Reference Number: CP.CPA.155
Effective Date: 11.16.16
Last Review Date: 11.19
Line of Business: Commercial

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Ivermectin (Soolantra®) is a semi-synthetic derivative isolated from the fermentation of Streptomyces avermitilis that belongs to the avermectin family of macrocyclic lactones.

FDA Approved Indication(s)

Soolantra is indicated for the treatment of inflammatory lesions of rosacea.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Soolantra is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Rosacea (must meet all)**:**

1. Diagnosis of rosacea;
2. Age ≥ 18 years;
3. Failure of ≥ 6 consecutive weeks of one of the following (*see Appendix B*) at maximally tolerated doses unless contraindicated or clinically significant adverse effects are experienced: oral doxycycline, oral minocycline, topical metronidazole, or topical azelaic acid;
4. Dose does not exceed 1 tube per month.

Approval duration: Length of Benefit

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial.

II. Continued Therapy

A. Rosacea (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 1 tube per month.

Approval duration: Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
metronidazole (Metrocream® 0.75%, Metrogel® 1%, Metrolotion® 0.75%)	Apply thin film topically to affected area QD for 1% and BID for 0.75%	Not applicable
azelaic acid (Finacea® 15% gel)	Apply in a thin film topically to the affected area BID Reassess if no improvement in 12 weeks	Not applicable
minocycline (Minocin®, Solodyn®)*	IR: 200 mg PO followed by 100 mg PO Q12H ER: 1 mg/kg PO QD	350 mg on day 1, then 200 mg/day
doxycycline (Oracea®)	40 mg PO once daily in the morning (1 hour before or 2 hours after a meal)	300 mg/day PO; 40 mg PO/day for Oracea

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Off-label*

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Rosacea	Apply pea size amount to the affected areas of the face QD	1 g/day

VI. Product Availability

Cream (30 g, 45 g, 60 g): 1%

VII. References

1. Soolantra Prescribing Information. Fort Worth, TX: Galderma Laboratories LP; July 2018. Available at: http://www.galdermausa.com/pi/soolantrapi.pdf. Accessed August 13, 2019.
2. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. Available at: http://www.clinicalpharmacology-ip.com. Accessed August 13, 2019.
3. Stein L, Kircik L, Fowler J, et al. Efficacy and safety of ivermectin 1% cream in treatment of papulopustular rosacea: results of two randomized, double-blind, vehicle-controlled pivotal studies. J Drugs Dermatol. 2014:13(3):316-323.
4. Oge' LK, Muncie HL, and Phillips-Savoy AR. Rosacea: diagnosis and treatment. American Family Physician. Am Fam Physician 2015;92(3):187-196.
5. Schaller M, Almeida LMC, Bewly A, et al. Rosacea treatment update: recommendations from the global ROSacea Consensus (ROSCO) panel. Br J Dermatol 2017; 176:465-471. DOI 10.1111/bjd.15173

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted to new template. Minor changes to verbiage and grammar. References updated.	01.17.17	11.17
4Q 2018 annual review: added age limit; added 6-week duration of trial for redirection; added maximum dose per PI and dose optimization; references reviewed and updated.	09.04.18	11.18
No significant changes, generalized dosing limits to 1 tube as quantity limit varies by plan.	12.19.18	
4Q 2019 annual review: no significant changes; references reviewed and updated.	08.13.19	11.19

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.