

## **Clinical Policy: Ivermectin (Sklice)**

Reference Number: HIM.PA.124

Effective Date: 12.01.17

Last Review Date: 08.18

Line of Business: HIM

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Ivermectin lotion (Sklice<sup>®</sup>) is a pediculicide.

### **FDA Approved Indication(s)**

Sklice is indicated for the topical treatment of head lice infestations in patients 6 months of age and older.

### **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<sup>®</sup> that Sklice is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Head Lice** (must meet all):

1. Diagnosis of head lice;
2. Age  $\geq$  6 months;
3. Failure of permethrin 1% cream in the last 60 days, unless contraindicated or clinically significant adverse effects are experienced;
4. Request does not exceed 1 tube for a single use.

**Approval duration: 14 days**

##### **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): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

#### **II. Continued Therapy**

##### **A. Head Lice** (must meet all):

1. New requests should be evaluated against the initial approval criteria.

**Approval duration: N/A**

##### **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 14 days (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): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

**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 – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid 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
permethrin 1% crème rinse/lotion	Adults, adolescents, children, and infants $\geq$ 2 months: Shampoo hair with regular shampoo, rinse and towel dry. Then, apply permethrin 1% lotion sufficient to saturate the hair and scalp (usually 25 to 30 mL), especially behind the ears and on the nape of the neck. Leave on hair for 10 minutes but no longer. Then, rinse thoroughly with water. If live lice are seen 7 days or more after the first application, a second treatment should be given.	One application to affected area

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*Appendix C: Contraindications*  
Not applicable

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Head lice	Apply to dry hair in an amount sufficient (up to 1 tube) to thoroughly coat the hair and scalp. Leave on the hair and scalp for 10 minutes, and then rinse off with water. The tube is intended for single use; discard any unused portion.	1 tube/topical application

**VI. Product Availability**

Lotion: 0.5%

**VII. References**

1. Sklice Prescribing Information. Atlanta, GA: Arbor Pharmaceuticals, LLC; January 2016. Available at: <https://www.sklice.com/>. Accessed April 10, 2018.
2. Centers for Disease Control and Prevention. Parasites-Lice-Head Lice. Available at: <https://www.cdc.gov/parasites/lice/head/treatment.html>. Updated August 19, 2016. Accessed April 10, 2018.
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2018. Available at: <http://www.clinicalpharmacology-ip.com/>.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	09.01.17	11.17
3Q 2018 annual review: modified timeframe of trial of permethrin from within the last 6 months to last 60 days; shortened approval duration from 1 month to 14 days since medication is intended for single use; continued therapy: removed requirement that 6 months should have elapsed since previous claim for Sklice; references reviewed and updated.	04.10.18	08.18

**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.

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**Note:**

**For Health Insurance Marketplace members**, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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