

POLICY NAME	Impavido (miltefosine)	POLICY #	2550P
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Criteria

Coverage Criteria

- ☐ Diagnosis of one of the following
 - Visceral leishmaniasis due to *Leishmania donovani*
 - Cutaneous leishmaniasis due to *Leishmania braziliensis*, *Leishmania guyanensis*, or *Leishmania panamensis*
 - Mucosal leishmaniasis due to *Leishmania braziliensis*
- ☐ Prescribed by or in consultation with an Infectious Disease Specialist
- ☐ Age 12 years or older weighing at least 30kg
- ☐ Documented failure, intolerance, or contraindication to Amphotericin B

Exclusion Criteria – Any of the following prevents coverage

- ☐ Pregnancy
- ☐ Sjogren-Larsson Syndrome