Pharmacy Drug Policy Checklist

POLICY NAME	Impavido (miltefosine)	POLICY #	2550P

Criteria

Coverage Criteria

- ☐ **1.1** 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
- ☐ **1.2** Prescribed by or in consultation with an Infectious Disease Specialist
- ☐ **1.3** Age 12 years or older weighing at least 30kg
- ☐ **1.4** Documented failure, intolerance, or contraindication to Amphotericin B

Exclusion Criteria – Any of the following prevents coverage

- ☐ **2.1** Pregnancy
- ☐ **2.2** Sjogren-Larsson Syndrome