**Topical Agents: Antiparasitics**

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| Criteria 1 | NP- Eurax, Ivermectin Lot, Malathion, Spinosad\*  \*- Preferred product has BvG designation |

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| **Criteria Title** | Topical Agents: Antiparasitics | | |
| **Criteria Subtitle** | Non-Preferred Drugs | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| EURAX | 007654 | GCNSeqNo |
| EURAX | 064724 | GCNSeqNo |
| IVERMECTIN LOT | 068579 | GCNSeqNo |
| MALATHION | 007657 | GCNSeqNo |
| SPINOSAD | 066988 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least one preferred drug?  The preferred alternatives may include: Natroba, Permethrin, Piperonyl Butoxide/Pyrethrins.  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 5 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | 1004 |
| 6 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1004 |
| N | 1235 |
| 7 | 1004 |  | Select | Is the request for generic spinosad? | Y | 1005 |
| N | END (Approve x 14 days) |
| 8 | 1005 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 14 days) |
| N | 1235 |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 14 Days

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| **Last Approved** | 5/5/2023 |
| **Other** |  |