Oscar Clinical Guideline: Emverm (mebendazole) (PG001, Ver. 6)

Emverm (mebendazole)

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Clinical guidelines are applicable according to policy and plan type. The Plan may delegate utilization management decisions of certain services to third parties who may develop and adopt their own clinical criteria.

Coverage of services is subject to the terms, conditions, and limitations of a member's policy, as well as applicable state and federal law. Clinical guidelines are also subject to in-force criteria such as the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) for Medicare Advantage plans. Please refer to the member's policy documents (e.g., Certificate/Evidence of Coverage, Schedule of Benefits, Plan Formulary) or contact the Plan to confirm coverage.

Summary

Emverm (mebendazole) is an antihelminthic medication used to treat various types of parasitic worm infections such as ascariasis, enterobiasis, hookworm infections, trichuriasis, angiostrongyliasis, baylisascariasis, capillariasis, toxocariasis, trichinellosis, and trichostrongyliasis. It functions by selectively and irreversibly blocking glucose uptake and other nutrients in susceptible adult intestine-dwelling helminths, leading to their eventual death and expulsion from the body. The medication is consumed as an oral chewable tablet, with dosage and duration varying based on the specific parasitic infection being treated.

Definitions

"Antihelminthic" refers to a class of medications that work against parasitic worms (helminths), expelling them from the body.

"Ascariasis," "Enterobiasis," "Hookworm Infections," "Trichuriasis," "Angiostrongyliasis," "Baylisascariasis," "Capillariasis," "Toxocariasis," "Trichinellosis," and **"Trichostrongyliasis"** are all different types of parasitic worm infections for which mebendazole is a recommended treatment.

"Helminths" are parasitic worms, which can infest various parts of the body, causing a range of health problems.

"Microtubules" are components of a cell's structure that help maintain its shape and integrity. In helminths, these microtubules are disrupted by mebendazole, leading to the parasites' death.

"Nematodes" refer to a type of helminth, commonly known as roundworms, that mebendazole can effectively treat.

Medical Necessity Criteria for Initial Authorization

The Plan considers **Emverm (mebendazole)** medically necessary when **ONE** of the following criteria is met:

1. The member has a documented diagnosis of **ONE** of the following:
    a. alveolar echinococcosis***; or***
    b. ascariasis caused by Ascaris lumbricoides (roundworm)***; or***
    c. baylisascariasis caused by Baylisascaris procyonis (raccoon roundworm)***; or***
    d. capillariasis caused by Capillaria philippinensis (Philippine threadworm)***; or***
    e. cystic echinococcosis (hydatid cyst disease)***; or***
    f. eosinophilic enterocolitis caused by Ancylostoma caninum (dog hookworm)***; or***
    g. eosinophilic meningitis caused by Angiostrongylus cantonensis***; or***
    h. toxocariasis (visceral larva migrans) caused by Toxocara canis or T. cati (dog or cat roundworm)***; or***
    i. trichinellosis (trichinosis) caused by Trichinella spiralis (pork worm)***; or***
    j. trichuriasis caused by Trichuris trichiura (whipworm)***; OR***
2. The member has **BOTH** of the following:
    a. a documented diagnosis of:
        i. enterobiasis caused by Enterobius vermicularis (pinworm)***; or***
        ii. intestinal hookworm infections caused by Ancylostoma duodenale or Necator americanus in single or mixed infections***; or***
        iii. trichostrongyliasis caused by Trichostrongylus***; or***

b. is unable to use, or has tried and failed over-the-counter (OTC) pyrantel pamoate

If the above prior authorization criteria are met, Emverm (mebendazole) will be approved for 1 month.

Medical Necessity Criteria for Reauthorization

All prior authorization renewals will be reviewed on a case-by-case basis to determine if continuation of therapy is medically necessary. The following should be provided for reauthorization:

1. Current clinical documentation supporting the need for continued therapy;
2. Response to the previous course of treatment;
3. Plan for the duration of continued treatment.

Prior Authorization may be extended based on the documentation provided, current treatment guidelines, and individual member needs.

Experimental or Investigational / Not Medically Necessary

Emverm (mebendazole) for any other indication is considered not medically necessary by the Plan, as it is deemed to be experimental, investigational, or unproven.

References

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Clinical Guideline Revision / History Information

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