Effective Date: 09/01/2021
Reviewed: 06/2021, 04/2022 Scope: Medicaid

Impavido (miltefosine)

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 28 days may be granted when all the following criteria are met:

A. Patient is patients 12 years of age and older; AND
B. Patient has documented diagnosis of one of the following:
    a. Visceral leishmaniasis caused by Leishmania donovani
    b. Cutaneous leishmaniasis caused by Leishmania braziliensis, Leishmania guyanensis and Leishmania panamensis
    c. Mucosal leishmaniasis caused by Leishmania braziliensis; AND
C. The patient is not pregnant; AND
D. The patient does not have Sjögren-Larsson-Syndrome; AND
E. Prescribed by, or in consultation with, an infectious disease specialist; AND
F. The member has experienced a failure, contraindication or intolerance to Amphotericin B

II. QUANTITY LIMIT

Impavido 50mg: 3 capsules per day

III. COVERAGE DURATION

28 days

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