

Effective Date: 09/01/2021
Reviewed: 06/2021, 04/2022, 4/2023
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