Pharmacy Medical Necessity Guidelines: Pediculicide Medications

Effective: September 15, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FDA-APPROVED INDICATIONS

Pediculicides are indicated for the topical treatment of head lice (pediculus capitis) infestation.

Spinosad topical suspension is a pediculicide indicated for the topical treatment of head lice infestations in patients 6 months of age and older. Spinosad is also a scabicide indicated for the topical treatment of scabies infestations in adults and pediatric patients 4 years of age and older.

Ivermectin (Sklice) lotion is a pediculicide indicated for the topical treatment of head lice infestations in patients 6 months of age and older.

COVERAGE GUIDELINES

The plan may authorize coverage of for Members when the following criteria for a particular regimen are met and limitations do not apply:

Spinosad Suspension

1. The Member meets **ONE** of the following:
    a. The Member meets ALL of the following:
        i. The Member has a diagnosis of head lice
        AND
        ii. The Member is 6 months of age or older
        AND
        iii. The Member had an inadequate response, intolerance, or contraindication to two treatment cycles (e.g., 0 and 9 days) in the last 30 days with, or the provider documents concern with the efficacy or safety of, an over-the-counter product (examples include permethrin, piperonyl butoxide/pyrethrins, and piperonyl butoxide/pyrethrins/permethrin)
        OR
    b. The Member meets ALL of the following:
        i. The Member has a diagnosis of scabies
        AND
        ii. The Member is 4 years of age or older
        AND
        iii. The Member had an inadequate response, intolerance, or contraindication to ONE of the following: permethrin or oral ivermectin

Sklice (ivermectin) lotion

1. The Member has a diagnosis of head lice
AND
2. The Member is at least 6 months of age
AND
3. The Member had an inadequate response, intolerance, or contraindication to two treatment cycles (e.g., 0 and 9 days) in the last 30 days with, or the provider documents concern with the efficacy or safety of, an over-the-counter product (examples include permethrin, piperonyl butoxide/pyrethrins, and piperonyl butoxide/pyrethrins/permethrin)

LIMITATIONS

1. Quantities for spinosad is limited to one package size per prescription, i.e., 120 mL per fill, providing one complete course of therapy per prescription.
2. Requests for brand-name products, which have AB-rated generics, will also be reviewed according to Brand Name Medications criteria.

CODES

None

REFERENCES

1. Goldstein BG, Goldstein AO. Scabies: management. UpToDate. Available at: www.uptodate.com. Accessed 31 July 2023.
2. Natroba (Spinosad) [prescribing information]. Carmel, IN: ParaPRO; May 2023 .
3. Note D, Moore S, Yan AC, Melnick L, and the Council on School Health and Committee on Infectious Diseases. Head lice. *Pediatrics.* 2022;150:e2022059282.
4. Sklice (Ivermectin) [prescribing information]. Atlanta, GA: Arbor Pharmaceuticals; April 2021.
5. Stough D, et al. Efficacy and safety of spinosad and permethrin creme rinses for pediculosis capitis (head lice). Pediatrics. 2009;124(3):e389-95.

APPROVAL HISTORY

October 11, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. September 12, 2023: Effective December 1, 2023, updated spinosad criteria to include diagnosis of scabies, and treatment of head lice now requires a documented diagnosis. Updated ivermectin lotion criteria to include diagnosis of head lice and removed step through with Spinosad for members 4 years of age and older. For both products updated the previous trial language.
2. September 10, 2024: Administrative change to fax number
3. September 9, 2025: No changes
4. September 15, 2026: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services