Clinical Policy: Atovaquone (Mepron)

Reference Number: IN.CP.PHAR.36
Effective Date: 01.01.2022
Last Review Date: 12.21
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Atovaquone (Mepron) is a antibacterial agent

FDA Approved Indication(s)
Mepron is indicated for **the** treatment of PCP in HIV-infected patients

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

I. Initial Approval Criteria

1. Must meet one of the following (a or b):
   a. Prophylaxis or treatment of Pneumocystis jirovecii pneumonia (PCP, PJP) AND one of the following:
      i. Previous trial and failure of sulfamethoxazole/trimethoprim
      ii. Prescriber has provided valid medical justification for the use of atovaquone over sulfamethoxazole/trimethoprim
2. Babesiosis AND the following Member will be using atovaquone concurrently with azithromycin
3. Prophylaxis or treatment of toxoplasma encephalitis in HIV-infected members
4. Treatment for ocular toxoplasmosis in immunocompetent patients
5. Not to exceed 3 grams per day

Approval duration: 12 months

A. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Must meet all for the following**:**
1. History of the requested agent within the past 90 days

Documentation from prescriber indicating improvement (including stabilization) in current clinical status

Approval duration:
Medicaid – **12** months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created for IN Medicaid Moratorium	12.2021	01.2022