

Ivermectin Topical Cream 1%

Criteria for Use

February 2025

VA Pharmacy Benefits Management Services and National Formulary Committee

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. THE CLINICIAN SHOULD USE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT. INDIVIDUAL CASES THAT ARE EXCEPTIONS TO THE EXCLUSION AND INCLUSION CRITERIA SHOULD BE ADJUDICATED AT THE LOCAL FACILITY ACCORDING TO THE POLICY AND PROCEDURES OF ITS P&T COMMITTEE AND PHARMACY SERVICES.

The Product Information should be consulted for detailed prescribing information.

Exclusion Criteria

None

Inclusion Criteria

All the following criteria must be selected to meet criteria.

- Provider is a VA dermatologist or other provider locally designated to prescribe ivermectin 1% cream
- Patient has documented diagnosis of papulopustular rosacea (may be mixed presentation with other rosacea subtype)
- Patient has an inadequate response despite appropriate trials of at least two alternative topical treatments alone and one trial of an alternative topical treatment in combination with an oral antibiotic ^{^1}

Other Justification

Footnotes

- 1 Oral antibiotics used in rosacea include doxycycline, minocycline, azithromycin, clarithromycin.

Prepared: February 2025.

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