

Clinical Policy Title:	quinine sulfate
Policy Number:	RxA.254
Drug(s) Applied:	Qualaquin®
Original Policy Date:	02/07/2020
Last Review Date:	01/01/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Malaria (must meet all):

1. Diagnosis of uncomplicated malaria;
2. Member meets one of the following (a or b)
 - a. Treatment in areas of chloroquine- sensitive malaria and trial and failure, contraindication, or intolerance to chloroquine or hydroxychloroquine;
 - b. Treatment in areas of chloroquine-resistant malaria;

Approval Duration

All Lines of Business (except Medicare): 7 days

II. Continued Therapy Approval

A. Malaria (must meet all):

1. Re-authorization is not permitted. Member must meet the initial approval criteria.

Approval Duration: Not applicable

References

1. Centers for Disease Control guidelines for treatment of malaria. Available at: <http://www.cdc.gov/malaria/resources/pdf/treatmenttable.pdf>. Accessed December 18, 2023.
2. Centers for Disease Control and Prevention. Parasites - Babesiosis: Treatment. https://www.cdc.gov/parasites/babesiosis/health_professionals/index.html. Accessed December 18, 2023.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed: 1. Clinical Policy Title was updated. 2. Line of Business Policy Applies to was updated to all lines of business. 3. Initial and Continued approval duration was updated to include Medicaid, Commercial & HIM approval duration. 4. References were reviewed and updated.	07/16/2020	09/14/2020

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

<p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. Last review date was updated. 2. Clinical policy verbiage added “ The provision of provider samples does not guarantee...”. 3. Continued Therapy criteria II.A.1 was rephrased from "Currently receiving medication that has been authorized by RxAdvance..." 4. References were reviewed and updated. 	<p>02/18/2021</p>	<p>06/10/2021</p>
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. Initial Approval Criteria I.A.1: Updated from Diagnosis of malaria to diagnosis of uncomplicated malaria; 2. Initial Approval Criteria I.A.2: Updated from Failure of a formulary antimalarial agent (e.g., atovaquone-proguanil, Coartem®, chloroquine, hydroxychloroquine, mefloquine) unless all are contraindicated or clinically significant adverse effects are experienced, or causative species is resistant to all formulary antimalarial agents to Member meets one of the following (a or b) <ol style="list-style-type: none"> a. Treatment in areas of chloroquine-sensitive malaria and trial and failure, contraindication, or intolerance to chloroquine or hydroxychloroquine; b. Treatment in areas of chlorquine. 3. References were reviewed and updated. 	<p>01/21/2022</p>	<p>04/18/2022</p>
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. Initial Approval Criteria I.B.2: Updated to add requirement for use in combination with clindamycin per IDSA and CDC. 2. References were reviewed and updated. 	<p>12/28/2022</p>	<p>04/13/2023</p>
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. Removed prior dosing criteria. 2. Updated approval duration. 3. Removed Babesiosis (off-label) indication. 	<p>12/18/2023</p>	<p>01/01/2024</p>

4. References were reviewed and updated.		
--	--	--