AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Xdemvy	Page:	1 of 1
Effective Date:	2/11/2026	Last Review Date:	1/2026

Applies to:	☒Illinois	☒New Jersey	☒Maryland
	☒Florida Kids	☒Pennsylvania Kids	☐Virginia

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Xdemvy under the patient's prescription drug benefit.

Description:

FDA-Approved Indication

Xdemvy is indicated for the treatment of Demodex blepharitis.

Applicable Drug List:

Xdemvy

Policy/Guideline:

Coverage Criteria

Demodex Blepharitis

Authorization may be granted when the requested drug is being prescribed for the treatment of Demodex blepharitis when ALL of the following criteria are met:

- The patient displays cylindrical dandruff at the base of the lash (collarettes).
- The patient has mild eyelid margin erythema.
- The requested drug is being prescribed by, or in consultation with an optometrist or ophthalmologist.

Approval Duration and Quantity Restrictions:

Approval: Xdemvy (lotilaner ophthalmic solution): 1 bottle (10 mL) / 6 weeks.

These drugs are for short-term acute use.

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

1. Xdemvy [package insert]. Irvine, CA: Tarsus Pharmaceuticals, Inc.; July 2023.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2025. https://online.lexi.com. Accessed September 05, 2025.
3. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 09/05/2025).
4. Rhee MK, Yeu E, Barnett M, et al. Demodex Blepharitis: A Comprehensive Review of the Disease, Current Management, and Emerging Therapies. Eye Contact Lens. 2023 Aug 1;49(8):311-318.