

Clinical Policy: Spinosad (Natroba)

Reference Number: HIM.PA.134

Effective Date: 12.01.17

Last Review Date: 08.26

Line of Business: HIM/ICHRA

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Spinosad topical suspension (Natroba®) is a pediculicide and scabicide.

FDA Approved Indication(s)

Natroba is indicated for the topical treatment of:

- Head lice infestations in patients 6 months of age and older
- Scabies infestations in adult and pediatric patients 4 years of age and older.

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.

It is the policy of health plans affiliated with Centene Corporation® that Natroba and Spinosad are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Head Lice** (must meet all):

1. Diagnosis of head lice;
2. Age $\geq$ 6 months;
3. Failure of permethrin 1% cream in the last 60 days, unless contraindicated or clinically significant adverse effects are experienced;[†]

[†]For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395

4. Request does not exceed both of the following (a and b):
 - a. 2 bottles;
 - b. 8 oz.

Approval duration: 14 days

B. Scabies Infestation (must meet all):

1. Diagnosis of scabies infestation;
2. Age $\geq$ 4 years;
3. Failure of permethrin 5% cream, unless contraindicated or clinically significant adverse effects are experienced;[†]

[†]For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 539

4. Request does not exceed both of the following (a and b):
 - a. 4 bottles;
 - b. 16 oz.

Approval duration: one time

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace/ICHRA; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace/ICHRA; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace/ICHRA.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Re-authorization is not permitted. Members must meet the initial approval criteria.
Approval duration: Not applicable

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace/ICHRA; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace/ICHRA; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace/ICHRA.

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 policy – HIM.PA.154 for health insurance marketplace/ICHRA or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
permethrin 1% creme rinse/lotion	Head lice: Adults, adolescents, children, and infants ≥ 2 months: Shampoo hair with regular shampoo, rinse and towel dry. Then, apply permethrin 1% lotion sufficient to saturate the hair and scalp (usually 25 to 30 mL), especially behind the ears and on the nape of the neck. Leave on hair for 10 minutes but no longer. Then, rinse thoroughly with water. If live lice are seen 7 days or more after the first application, a second treatment should be given.	One application to affected area
permethrin 5% cream	Scabies: Adults, adolescents, children and infants ≥ 2 months: Thoroughly massage permethrin 5% cream into the skin from the head to the soles of the feet. Scabies rarely infests the scalp of adults, although the hairline, neck, temple, and forehead may be infested in geriatric patients. Usually 30 grams is sufficient for an average adult. The cream should be removed by washing (shower or bath) after 8 to 14 hours. One application is generally curative. Patients may experience persistent pruritus after treatment. This is rarely a sign of treatment failure and is not an indication for retreatment. Retreatment is indicated if living mites persist after 7 to 14 days of initial treatment.	One application to affected area

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Head lice	Apply a sufficient amount to cover dry scalp and hair; up to 1 bottle (120 mL) may be required depending on the length of hair. Leave on for 10	120 mL/application

Indication	Dosing Regimen	Maximum Dose
	minutes, then thoroughly rinse off with warm water. If live lice are seen 7 days after the first treatment, a second treatment should be applied.	
Scabies infestation	Apply a sufficient amount of Natroba to skin to completely cover the body from the neck to the toes (including the soles of the feet). For patients with balding scalp, also apply product to the scalp, hairline, temples, and forehead. Allow to absorb into the skin and dry for 10 minutes before getting dressed. Leave on the skin for at least 6 hours before showering or bathing.	Varies per body surface area

VI. Product Availability

Suspension: 9 mg of spinosad per gram of Natroba topical suspension in 120 mL bottles

VII. References

1. Natroba Prescribing Information. Carmel, IN: ParaPRO LLC; April 2021. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/022408Orig1s0101bl.pdf. Accessed May 21, 2026.
2. Centers for Disease Control and Prevention. Treatment of Head Lice. Available at: https://www.cdc.gov/lice/treatment/?CDC_AAref_Val=https://www.cdc.gov/parasites/lice/head/treatment.html. Accessed May 21, 2026.
3. Centers for Disease Control and Prevention. Clinical Care of Scabies. Available at: https://www.cdc.gov/scabies/hcp/clinical-care/?CDC_AAref_Val=https://www.cdc.gov/parasites/scabies/treatment.html. Accessed May 21, 2026.
4. Clinical Pharmacology [database online]. Philadelphia, PA: Elsevier; 2026. Available at: <https://www.clinicalkey.com/pharmacology/>. Accessed May 21, 2026.
5. Nolt D, Moore S, Yan AC, Melnick L; Committee on Infectious Diseases, Committee on Practice and Ambulatory Medicine, Section on dermatology. Head Lice. American Academy of Pediatrics. 2022 Oct 1;150(4):e2022059282. doi: 10.1542/peds.2022-059282.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Template changes applied to other diagnoses/indications.	10.11.22	
3Q 2023 annual review: no significant changes; references reviewed and updated.	04.25.23	08.23
3Q 2024 annual review: no significant changes; for Appendix B, updated dosing regimen for permethrin 5%; references reviewed and updated.	05.13.24	08.24
3Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.	04.14.25	08.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2026 annual review: no significant changes; added generic Spinosad to medically necessary statement; added ICHRA line of business; references reviewed and updated.	04.20.26	08.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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