

Clinical Policy: Tedizolid (Sivextro)

Reference Number: LA.PMN.62

Effective Date:

Last Review Date: 03.21

Line of Business: Medicaid

Coding Implications

Revision Log

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

Description

Tedizolid (Sivextro®) is an oxazolidinone-class antibacterial agent.

FDA Approved Indication(s)

Sivextro is indicated in adult and pediatric patients 12 years of age and older for the treatment of acute bacterial skin and skin structure infections (ABSSSI) caused by susceptible isolates of the following gram-positive microorganisms:

- *Staphylococcus aureus* (including methicillin-resistant [MRSA] and methicillin-susceptible [MSSA] isolates)
- *Streptococcus pyogenes*
- *Streptococcus agalactiae*
- *Streptococcus anginosus* Group (including *Streptococcus anginosus*, *Streptococcus intermedius*, and *Streptococcus constellatus*)
- *Enterococcus faecalis*

To reduce the development of drug-resistant bacteria and maintain the effectiveness of Sivextro and other antibacterial drugs; Sivextro should be used only to treat ABSSSI that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy.

Policy/Criteria

Prior authorization is required. 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 Louisiana Healthcare Connections that Sivextro is medically necessary when the following criteria are met:

I. Initial Approval Criteria

A. Acute Bacterial Skin and Skin Structure Infections (must meet all):

1. Diagnosis of ABSSSI;
2. Age ≥ 12 years;
3. Member meets one of the following (a or b):
 - a. Request is for continuation of therapy initiated in an acute care hospital from which member was discharged;

- b. Both of the following (i and ii):
 - i. Culture and sensitivity (C&S) report for the current infection shows isolated pathogen is a gram-positive bacteria susceptible to tedizolid, unless provider submits documentation that obtaining a C&S report is not feasible;
 - ii. Member meets one of the following (a, b, or c):
 - a) Failure of ≥ 2 formulary antibiotics to which the isolated pathogen is susceptible (if available) per C&S report, unless all are contraindicated or clinically significant adverse effects are experienced;
 - b) C&S report shows resistance or lack of susceptibility of the isolated pathogen to all formulary antibiotics FDA-approved for member's diagnosis;
 - c) If provider documents that obtaining a C&S report is not feasible: Failure of ≥ 2 formulary antibiotics indicated for member's diagnosis (if available), unless all are contraindicated or clinically significant adverse effects are experienced;
- 4. Dose does not exceed 200 mg (1 vial) per day.
Approval duration: 6 days

B. Other diagnoses/indications

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

II. Continued Therapy

A. Acute Bacterial Skin and Skin Structure Infections (must meet all):

- 1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
 - b. Request is for continuation of therapy initiated in an acute care hospital from which member was discharged;
- 2. Member is responding positively to therapy;
- 3. Member has not received ≥ 6 days of therapy for current infection;
- 4. Request does not exceed 200 mg (1 vial) per day.
Approval duration: Up to 6 days

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

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

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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 – LA.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ABSSSI: acute bacterial skin and skin structure infections

C&S: culture and sensitivity

FDA: Food and Drug Administration

MRSA: methicillin-resistant

Staphylococcus aureus

MSSA: methicillin-susceptible

Staphylococcus aureus

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may require prior authorization.

<u>Drug Name</u>	<u>Dosing Regimen</u>	<u>Dose Limit/ Maximum Dose</u>
<u>Therapeutic alternatives include formulary antibiotics that are indicated for member's diagnosis and have sufficient activity against the offending pathogen at the site of the infection.</u>		

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

- Contraindication(s): none reported
- Boxed Warning(s): none reported

V. Dosage and Administration

<u>Indication</u>	<u>Dosing Regimen</u>	<u>Maximum Dose</u>
<u>ABSSSI</u>	<u>200 mg once daily IV over 1 hour for six days</u>	<u>200 mg/day</u>

VI. Product Availability

- Single-use vial: 200 mg, sterile, lyophilized powder for reconstitution

VII. References

1. Sivextro Prescribing Information. Whitehouse Station, NJ: Merck & Co., Inc.; October 2020. Available at: https://www.merck.com/product/usa/pi_circulars/s/sivextro/sivextro_pi.pdf. Accessed November 24, 2020.
2. Liu, C, Bayer A, Cosgrove SE et al. Clinical practice guidelines by the Infectious Diseases Society of America for the treatment of methicillin-resistant staphylococcus aureus infections in adults and children. Clin Infect Dis. 2011 Feb; 52:1-38. Clinical Infectious Diseases; 2011; 52:1-38.

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3. Stevens DL, Bisno AL, Chambers HF, et al. Practice guidelines for the diagnosis and management of skin and soft-tissue infections: 2014 Update by the Infectious Diseases Society of America. Clinical Infectious Diseases. April 2014;59(2):10-52.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<u>HCPCS Codes</u>	<u>Description</u>
<u>J3090</u>	<u>Injection, tedizolid phosphate, 1 mg</u>

<u>Reviews, Revisions, and Approvals</u>	<u>Date</u>
<u>Converted corporate to local policy</u>	<u>03.2021</u>

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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to

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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. LHCC 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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