MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 26, 2019

TO: Custodians of Medicaid Services Manual

FROM: Lynne Foster, Chief of Division Compliance

SUBJECT: Medicaid Services Manual Changes
Chapter 1200 – Prescribed Drugs

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1200, Appendix A, are being proposed to reflect recommendations approved on July 26, 2018 by the Drug Use Review (DUR) Board. The proposed changes include the addition of new prior authorization criteria for antibiotic medications (third generation cephalosporins, fluoroquinolones and oxazolidinones).

These changes are effective March 4, 2019.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 32308 MSM Chapter 1200 – Prescribed Drugs	MTL NEW MSM Chapter 1200 – Prescribed Drugs

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A, Section YYY	**Antibiotics**	Addition of new prior authorization criteria for Antibiotics.

YYY. Antibiotics

Last Reviewed by the DUR Board: July 26, 2018

Antibiotic medications are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

The outpatient antibiotic class criteria apply to the following:

1. Third Generation Cephalosporins: cefixime, cefdinir, cefpodoxime, ceftibuten and cefditoren

2. Fluoroquinolones: ciprofloxacin, levofloxacin, delafloxacin, moxifloxacin and ofloxacin

3. Oxazolidinones: tedizolid and linezolid

If applicable, reference current Infectious Disease Society of America (IDSA) (or equivalent organization) guidelines to support the use of the following:

1. Coverage and Limitations for Third Generation Cephalosporins and Fluoroquinolones

   Approval will be given if the following criteria are met and documented:

   a. Culture and sensitivity-proven susceptibilities and resistance to other agents suggest the requested drug is necessary.

2. Coverage and Limitations for Oxazolidinones

   a. Sivextro (tedizolid)

      Approval will be given if the following criteria are met and documented:

      1. Recipient has diagnosis of Acute Bacterial Skin and Skin Structure Infection; and

      2. Infection is caused by methicillin-resistant *Staphylococcus aureus* (MRSA); and

      3. Recipient has had a trial of or has a contraindication to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns, examples of alternative antibiotics may include, but are not limited to: TMP/SMX, doxycycline, vancomycin, daptomycin, telavancin, clindamycin); or

4. Recipient started treatment with intravenous antibiotic(s) in the hospital and requires continued outpatient therapy.

b. Zyvox (linezolid)

Approval will be given if the following criteria are met and documented:

1. Recipient has diagnosis of vancomycin-resistant *enterococcus* (VRE) *faecium* infection or diagnosis of MRSA infection; and

2. Recipient has had a trial of or has a contraindication to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns, examples of alternative antibiotics may include, but are not limited to: TMP/SMX, doxycycline, vancomycin, tetracycline, clindamycin); or

3. Recipient started treatment with intravenous antibiotic(s) in the hospital and requires continued outpatient therapy.

3. Exception Criteria (applies to antibiotic medications):

a. Prescribed by an infectious disease specialist or by an emergency department provider; or

b. Ceftriaxone prescribed as first line treatment for gonorrhea, pelvic inflammatory disease, epididymo-orchitis and as an alternative to benzylpenicillin to treat meningitis for those with a severe penicillin allergy; or

c. If Cefixime is prescribed for gonococcal infection where Ceftriaxone is unavailable; or

d. The recipient resides in one of the following:

1. Acute Care

2. Long-term Acute Care (LTAC)

3. Skilled Nursing Facility (SNF)

4. Prior Authorization Guidelines

a. Prior authorization approval will be for a single course.

b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

5. References:

a. CDC Antibiotic Prescribing and Use in Doctor's Offices: https://www.cdc.gov/antibiotic-use/community/for-hcp/outpatient-hcp/index.html

b. CDC Improving Prescribing: https://www.cdc.gov/antibiotic-use/community/improving-prescribing/index.html

c. IDSA Guidelines: https://www.idsociety.org/practice-guidelines/#/score/DESC/0/+/