

**Policy: MBP 203.0**

**Section: Medical Benefit Pharmaceutical Policy**

**Subject: Nuzyra (omadacycline) Injection**

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### **I. Policy:**

Nuzyra (omadacycline) Injection

### **II. Purpose/Objective:**

To provide a policy of coverage regarding Nuzyra (omadacycline) Injection

### **III. Responsibility:**

- A. Medical Directors
- B. Medical Management
- C. Pharmacy Department

### **IV. Required Definitions**

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than
3. the department requiring/authoring the policy.
4. Devised – the date the policy was implemented.
5. Revised – the date of every revision to the policy, including typographical and grammatical changes.
6. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

### **V. Additional Definitions**

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards good medical treatment practiced by the general medical community;
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient

### **Medicaid Business Segment**

**Medically Necessary** — A service, item, procedure, or level of care compensable under the Medical Assistance program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- i. Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- ii. Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- iii. Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

**DESCRIPTION:**

Nuzyra (omadacycline) Injection is a tetracycline derivative antibiotic that inhibits protein synthesis by binding with the 30S ribosomal subunit of susceptible bacteria.

**CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee**

Nuzyra (omadacycline) will be considered medically necessary for the commercial, exchange, CHIP, and Medicaid lines of business when ALL of the following criteria are met:

- Prescription is written by or in consultation with Infectious Disease **AND**
- Medical record documentation of member is greater than or equal to 18 years of age **AND**
- Medical record documentation of one of the following:
  - Diagnosis of Community-acquired bacterial pneumonia caused by *Streptococcus pneumoniae*, *Staphylococcus aureus* (methicillin-susceptible isolates), *Haemophilus influenzae*, *Haemophilus parainfluenzae*, *Klebsiella pneumoniae*, *Legionella pneumophila*, *Mycoplasma pneumoniae*, or *Chlamydia pneumoniae* **OR**
  - Diagnosis of an acute bacterial skin and skin structure infection (including cellulitis/erysipelas, wound infection, and major cutaneous abscess) caused by *Staphylococcus aureus* (methicillin-susceptible and -resistant isolates), *Staphylococcus lugdunensis*, *Streptococcus pyogenes*, *Streptococcus anginosus* grp. (includes *S. anginosus*, *S. intermedius*, and *S. constellatus*), *Enterococcus faecalis*, *Enterobacter cloacae*, or *Klebsiella pneumoniae*.
- Medical record documentation of a culture and sensitivity showing the patient's infection is not susceptible to alternative antibiotic treatments **OR** a documented history of previous intolerance to or contraindication to three (3) alternative antibiotics shown to be susceptible on the culture and sensitivity **OR**
- Medical record documentation that treatment with Nuzyra was initiated during an inpatient setting

**QUANTITY LIMITS:** Facets RX Count: up to 1500 units (15 vials per 14 days)

**AUTHORIZATION DURATION:** Approvals will be given for up to 14 days of treatment.

Nuzyra (omadacycline) will be considered medically necessary for the Medicare line of business when ALL of the following criteria are met:

- Prescription is written by or in consultation with Infectious Disease **AND**
- Medical record documentation of member is greater than or equal to 18 years of age **AND**
- Medical record documentation of one of the following:
  - Diagnosis of Community-acquired bacterial pneumonia caused by *Streptococcus pneumoniae*, *Staphylococcus aureus* (methicillin-susceptible isolates), *Haemophilus influenzae*, *Haemophilus parainfluenzae*, *Klebsiella pneumoniae*, *Legionella pneumophila*, *Mycoplasma pneumoniae*, or *Chlamydia pneumoniae* **OR**
  - Diagnosis of an acute bacterial skin and skin structure infection (including cellulitis/erysipelas, wound infection, and major cutaneous abscess) caused by *Staphylococcus aureus* (methicillin-susceptible and -resistant isolates), *Staphylococcus lugdunensis*, *Streptococcus pyogenes*, *Streptococcus anginosus* grp. (includes *S. anginosus*, *S. intermedius*, and *S. constellatus*), *Enterococcus faecalis*, *Enterobacter cloacae*, or *Klebsiella pneumoniae*.

**QUANTITY LIMITS:** Facets RX Count: up to 1500 units (15 vials per 14 days)

**AUTHORIZATION DURATION:** Approvals will be given for up to 14 days of treatment.

Note: For Medicaid (GHP Family), any requests for services that do not meet criteria set in the PARP will be evaluated on a case-by-case basis.

**LINE OF BUSINESS:**

**Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy.**

This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 11/19/19

**Revised:** 12/30/20 (per DHS), 10/4/22 (Medicaid PARP statement), 10/2/23 (LOB carve out, Medicaid business segment)

**Reviewed:** 11/2/20, 10/4/21