Clinical Policy: Linezolid Tablets (Zyvox)
Reference Number: HIM.PA.104
Effective Date: 08/15
Last Review Date: 05/17
Line of Business: Health Insurance Marketplace

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Linezolid (Zyvox®) is a synthetic antibacterial agent of the oxazolidinone class.

FDA approved indication
Zyvox is indicated in adults and children for the treatment of the following infections caused by susceptible gram-positive bacteria:

- Nosocomial pneumonia caused by Staphylococcus aureus (methicillin-susceptible and -resistant isolates) or Streptococcus pneumoniae;
- Community-acquired pneumonia caused by Streptococcus pneumoniae, including cases with concurrent bacteremia, or Staphylococcus aureus (methicillin-susceptible isolates only);
- Complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis, caused by Staphylococcus aureus (methicillin-susceptible and -resistant isolates), Streptococcus pyogenes, or Streptococcus agalactiae. Zyvox has not been studied in the treatment of decubitus ulcers;
- Uncomplicated skin and skin structure infections caused by Staphylococcus aureus (methicillin-susceptible isolates only) or Streptococcus pyogenes;
- Vancomycin-resistant Enterococcus faecium infections, including cases with concurrent bacteremia.

Policy/Criteria
Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria

I. Initial Approval Criteria

A. All FDA Approved Indications (must meet all)**:**

1. Prescribed by or in consultation with an infectious disease specialist;
2. Culture and sensitivity (C&S) report dated within the past 7 days shows isolated pathogen is a gram-positive bacteria susceptible to linezolid, unless provider submits documentation that obtaining a C&S report is not feasible;
3. Member meets one of the following (a, b, c, or d):
   a. Failure of ≥ 2 formulary antibiotics to which the isolated pathogen is susceptible, unless all are contraindicated or clinically significant adverse effects are experienced;
   b. C&S report shows resistance of the isolated pathogen to ALL formulary antibiotics FDA-approved for member's diagnosis;
   c. Provider documents that obtaining a C&S report is not feasible, and member has tried and failed 2 formulary antibiotics indicated for member's diagnosis (if

applicable) unless all are contraindicated or clinically significant adverse effects are experienced;
   d. Formulary antibiotics are not indicated for member's diagnosis;
4. Dose does not exceed 1200 mg per day (2 tablets per day).

Approval duration: 14-day supply

B. Other diagnoses/indications - Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All FDA Approved Indications (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member has not received ≥ 28 days of therapy for current infection;
3. If request is for a dose increase, new dose does not exceed 1200 mg per day (2 tablets per day).

Approval duration: Up to an additional 14-day supply (28 days of therapy total)

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
2. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

Approval duration: 14-day supply

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.PHAR.21 or evidence of coverage documents

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
C&S: culture and sensitivity
FDA: Food and Drug Administration

V. References

1. Zyvox® Prescribing Information. New York, NY; Pfizer Inc.; July 2015. Available at: http://www.zyvox.com/. Accessed January 4, 2017.
2. Linezolid Drug Monograph. Clinical Pharmacology. Accessed January 2017. http://www.clinicalpharmacology-ip.com.
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. Clin Infect Dis 2014; Jul 15;59(2):147-59.
4. Ament PW, Jamshed, N., Horne JP. Linezolid: Its Role in the Treatment of Gram-Positive, Drug-Resistant Bacterial Infections. Am Fam Physician. 2002 Feb 15;65(4):663-671. www.aafp.org/afp/20020215/663.html.

5. C Liu et al. Management of Patients with Infections Caused by Methicillin-Resistant Staphylococcus Aureus: Clinical Practice Guidelines by the Infectious Diseases Society of America (IDSA Clinical Infectious Diseases; 2011;52:1-38.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Removed requirement related to documentation of an FDA approved indication. Added prescriber specialty. Added that culture and sensitivity report must show pathogen susceptibility to linezolid and be dated within the last 7 days. Added requirement related to trial and failure of formulary antibiotics to which pathogen is susceptible, unless contraindicated to such therapies, or culture and sensitivity report shows resistance of pathogen to formulary antibiotics. Updated continuation criteria. Updated references. Changed guideline to new format.	11/16	11/16
Clinical changes made to criteria: -Modified criteria to allow for cases in which obtaining C&S report is not feasible per documentation from the provider -Removed language specifying "Isolated pathogen is VRE" since VRE is gram-positive and policy covers gram positive bacteria -Added max dose requirement in initial approval criteria Non-clinical changes made: -Converted to new template -Updated policy name to reflect linezolid tablets since the oral suspension is on the formulary and does not require a PA -Updated references	01/17	

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.