Clinical Policy: tedizolid (Sivextro®)
Reference Number: NE.PMN.62
Effective Date: 01/01/2017
Last Review Date:

**IMPORTANT REMINDER**
This Clinical Policy has been developed by appropriately experienced and licensed health care professionals based on a thorough 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 the policy; and other indicia of medical necessity. Centene Corporation makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this policy.

The purpose of this Clinical Policy is to provide a guide to medical necessity. Benefit determinations should be based on the applicable contract provisions governing plan benefits (“Benefit Plan Contract”) and applicable state and federal requirements, as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between this Clinical Policy and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies are intended to be reflective of current scientific research and clinical thinking. This policy is current at the time of approval, may be updated and therefore is subject to change. This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.

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**Description**
The intent of the criteria is to ensure that patients follow selection elements established by Centene medical policy tedizolid (Sivextro®)

**Policy/Criteria**
It is the policy of health plans affiliated with Centene Corporation® that tedizolid (Sivextro®) is medically necessary for members meeting the following criteria:

**Initial Approval Criteria** (must meet all):
A. Prescribed by or in consultation with an infectious disease specialist;
B. Documentation of a recent (dated within past 7 days) culture and sensitivity report demonstrating that the isolated pathogen is susceptible to tedizolid;
C. Isolated pathogen is VRE or MRSA AND the pathogen is NOT susceptible to any formulary antibiotic FDA-approved for patient’s diagnosis

OR

Member has failed at least TWO formulary antibiotic FDA approved for member’s diagnosis, unless isolated pathogen is resistant to, or member has contraindication(s) to all formulary medications approved by the FDA for member’s diagnosis.

D. Request does not exceed 1 tablet per day.

Approval duration: 6 days

Continued Approval (must meet all as applicable):
A. Member is currently receiving this medication per provider’s documentation or pharmacy record;
B. Member has not received ≥ 6 days of therapy for current infection;
C. Request must not exceed 1 tablet per day.

Approval duration: Allow no more than 6 days of therapy total

Background
Tedizolid is a synthetic oxazolidinone antimicrobial agent. It has clinical utility in the treatment of acute bacterial skin and skin structure infections. It is approved by the FDA for the following: Acute bacterial skin and skin structure infections (ABSSSI) caused by designated susceptible bacteria.

- Staphylococcus aureus (Methicillin-Resistant and Methicillin-Susceptible strains)
- Streptococcus pyogenes
- Streptococcus agalactiae
- Streptococcus anginosus
- Enterococcus faecalis

References (or Bibliography):
tedizolid (Sivextro®)

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