

Clinical Policy: Infectious Disease Agents: Antibiotics - Tetracyclines

Reference Number: OH.PHAR.PPA.69

Effective Date: 01/01/2020

Last Review Date: 10.20

Line of Business: Medicaid

[Coding Implications](#)
[Revision Log](#)

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

Description:

TETRACYCLINES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Doxycycline tablets, capsules 50mg & 100mg Doxycycline syrup Minocycline capsules Tetracycline capsules VIBRAMYCIN® susp (doxycycline) – No PA Required for age 12 or under	Doxycycline (generic of DORYX®) Doxycycline tablets, capsules 20mg, 40mg, 75mg, & 150mg Doxycycline DR Minocycline ER MINOLIRA™ ER (minocycline) SEYSARA™ (sarecycline) SOLODYN® ER (minocycline) VIBRAMYCIN® susp (doxycycline) – PA required for age over 12 Minocycline (generic XIMINO®)

TETRACYCLINES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	NUZYRA® (omadacycline)

FDA Approved Indication(s):

Tetracyclines are indicated for the treatment of:

- [acne vulgaris](#)
- [actinomycosis](#)
- [amebiasis](#)
- [anthrax](#)
- [anthrax prophylaxis](#)
- [bacterial conjunctivitis](#)
- [bartonellosis](#)
- [brucellosis](#)
- [cellulitis](#)
- [cervicitis](#)
- [chancroid](#)
- [chlamydia infection](#)
- [cholera](#)
- [community-acquired pneumonia](#)
- [endocarditis](#)

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- [epididymitis](#)
- [erythema migrans](#)
- [gonorrhea](#)
- [granuloma inguinale](#)
- [listeriosis](#)
- [lower respiratory tract infections](#)
- [Lyme disease](#)
- [lymphogranuloma venereum](#)
- [malaria prophylaxis](#)
- [murine typhus](#)
- [necrotizing ulcerative gingivitis](#)
- [non-gonococcal urethritis \(NGU\)](#)
- [periodontitis](#)
- [pharyngitis](#)
- [plague](#)
- [pneumonia](#)
- [psittacosis](#)
- [Q fever](#)
- [relapsing fever](#)
- [Rickettsial pox](#)
- [Rocky Mountain spotted fever](#)
- [scrub typhus](#)
- [sinusitis](#)
- [skin and skin structure infections](#)
- [syphilis](#)
- [tularemia](#)
- [upper respiratory tract infections](#)
- [urethritis](#)
- [urinary tract infection \(UTI\)](#)
- [yaws](#)

Policy/Criteria

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 Buckeye Health Plan, an affiliate of Centene Corporation[®], that Doryx, Doxycycline tablets, capsules 20mg, 40mg, 75mg, & 150mg, Doxycycline DR, Minocycline ER, Minolira ER, Seysara, Solodyn ER, Ximino, and Nuzyra are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. For Doryx, Doxycycline tablets, capsules 20mg, 40mg, 75mg, & 150mg, Doxycycline DR, Minocycline ER, Minolira ER, Solodyn ER, Vibramycin suspension, and Ximino (must meet all):

1. FDA-approved or supported by standard pharmacopeias;
2. For Minolira ER, Solodyn ER, Vibramycin suspension and Ximino requests: Age \geq 12 years;

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3. The member meets one of the following (a, b, or c):
 - a. Documentation that the infection is caused by an organism resistant to medications not requiring prior approval (note diagnosis and any culture and sensitivity reports);
 - b. Documentation that there have been therapeutic failures to no less than a 3 day trial of at least one medication not requiring prior approval UNLESS there is a reason the member cannot be changed to a preferred medication. Acceptable reasons include:
 - Allergies to all medications not requiring prior approval.
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
 - History of unacceptable/toxic side effects to medications not requiring prior approval.
 - c. Documentation that the member is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital.

Approval duration: 84 days.

B. For Seysara (sarecycline) (must meet all):

1. Diagnosis of acne vulgaris;
2. Age ? 9 years;
3. The member meets one of the following (a, b, or c):
 - a. Documentation that the infection is caused by an organism resistant to medications not requiring prior approval (note diagnosis and any culture and sensitivity reports);
 - b. Documentation that there have been therapeutic failures to no less than a 3 day trial of at least one medication not requiring prior approval UNLESS there is a reason the member cannot be changed to a preferred medication. Acceptable reasons include:
 - Allergies to all medications not requiring prior approval.
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
 - History of unacceptable/toxic side effects to medications not requiring prior approval.
 - c. Documentation that the member is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital.

Approval duration: 84 days.

C. For Nuzyra (omadacycline) (must meet all):

1. Diagnosis of Community-Acquired Bacterial Pneumonia (CABP) with prior failure of other first line agent OR diagnosis of Acute Bacterial Skin and Skin Structure Infection (ABSSSI) with prior failure of other first line agent;
2. Age ? 18 years;
3. The member meets one of the following (a, b, or c):
 - a. Documentation that the infection is caused by an organism resistant to medications not requiring prior approval (note diagnosis and any culture and sensitivity reports);

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- b. Documentation that the member cannot be changed to a medication not requiring prior approval. Acceptable reasons include:
 - Allergies to all medications not requiring prior approval.
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
 - History of unacceptable/toxic side effects to medications not requiring prior approval.
 - c. Documentation that the member is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital.
- Approval duration:** 14 days.

D. Other diagnoses/indications:

1. There are no pharmacy and therapeutic committee approved off-label use criteria for the diagnosis;
2. Use is supported by one of the following (a, b, or c):
 - a. The National Comprehensive Cancer Network (NCCN) Drug Information and Biologics Compendium level of evidence 1 or 2A;
 - b. Evidence from at least two high-quality, published studies in reputable peer-reviewed journals or evidence-based clinical practice guidelines that provide all of the following (i – iv):
 - i. Adequate representation of the member’s clinical characteristics, age, and diagnosis;
 - ii. Adequate representation of the prescribed drug regimen;
 - iii. Clinically meaningful outcomes as a result of the drug therapy in question;
 - iv. Appropriate experimental design and method to address research questions;
 - c. Micromedex DrugDex[®] with strength of recommendation Class I, IIa, or IIb;
3. Prescribed by or in consultation with an appropriate specialist for the diagnosis;
4. Failure of an adequate trial of at least two FDA-approved drugs for the indication and/or drugs that are considered the standard of care, when such agents exist for the same indication at maximum indicated doses, unless no such drugs exist, at maximum indicated doses, unless contraindicated or clinically significant adverse effect are experienced;
5. Dosing regimen and duration are within dosing guidelines recommended by clinical practice guidelines and/or medical literature.

Approval duration: 84 days.

II. Diagnoses/Indications for which coverage is NOT authorized:

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

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ABSSSI: Acute Bacterial Skin and Skin Structure Infection

CABP: Community-Acquired Bacterial Pneumonia

DR: Delayed Release

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ER: Extended Release
 FDA: Food and Drug Administration
 NGU: Non-Gonococcal Urethritis
 PA: Prior Authorization
 UTI: Urinary Tract Infection

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Doxycycline tablets, capsules 50mg & 100mg, Doxycycline syrup	<p>Bacterial urinary tract infection (UTI) 100 mg every 12 hours on day 1, then 100 mg once daily. For severe infections, including chronic urinary tract infections, continue 100 mg every 12 hours.</p> <p>Upper respiratory tract infections 100 mg every 12 hours on day 1, then 100 mg once daily. For severe infections, 100 mg every 12 hours.</p> <p>Nonspecific lower respiratory tract infections (LRTIs) 100 mg every 12 hours on day 1, then 100 mg once daily. For severe infections, 100 mg every 12 hours.</p> <p>Community-acquired pneumonia (CAP) 100 mg every 12 hours for at least 5 days.</p> <p>Severe acne vulgaris as adjunctive therapy 100 mg every 12 hours on day 1, then 100 mg once daily.</p> <p>Cholera 100 mg every 12 hours on day 1, then 100 mg once daily.</p> <p>Primary, secondary, or early latent syphilis (caused by <i>Treponema pallidum</i>) in nonpregnant, penicillin-allergic patients 100 mg twice daily for 14 days.</p>	300 mg/day; 600 mg in a single physician's visit for acute gonococcal infections.

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Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Doxycycline tablets, capsules 50mg & 100mg, Doxycycline syrup - continued	<p>Late latent syphilis in nonpregnant, penicillin-allergic patients 100 mg twice daily for 4 weeks.</p> <p>Uncomplicated gonorrhea 100 mg twice daily for 7 days in combination with ceftriaxone 250 mg IM.</p> <p>Early Lyme disease (erythema migrans) 100 mg every 12 hours for 21 days.</p> <p>Malaria prophylaxis 100 mg once daily. Begin 1 to 2 days prior to travel and continue during the stay and for 4 weeks after returning home.</p> <p>Cutaneous anthrax infection 100 mg every 12 hours. Treat for 7 to 10 days for naturally acquired infection. For a bioterrorism event, treat for 60 days.</p> <p>Anthrax prophylaxis after exposure 100 mg every 12 hours for 60 days.</p>	300 mg/day; 600 mg in a single physician's visit for acute gonococcal infections.
Minocycline capsules	<p>Lower respiratory tract infections and upper respiratory tract infections 200 mg initially, then 100 mg every 12 hours. Alternatively, 100 to 200 mg initially, then 50 mg every 6 hours.</p> <p>Urinary tract infection (UTI) 200 mg initially, then 100 mg every 12 hours. Alternatively, 100 to 200 mg initially, then 50 mg every 6 hours.</p> <p>Cholera 200 mg initially, then 100 mg every 12 hours. Alternatively, 100 to 200 mg initially, then 50 mg every 6 hours.</p> <p>Acne vulgaris 200 mg initially, then 100 mg every 12 hours as adjunctive therapy. Alternatively, 100 to 200 mg initially, then 50 mg every 6 hours.</p>	300 mg on day 1, then 200 mg/day.

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Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Tetracycline capsules	<p>Primary, secondary, or early latent syphilis (caused by <i>Treponema pallidum</i>) in nonpregnant, penicillin-allergic patients 500 mg every 6 hours for 14 days.</p> <p>Late latent syphilis in nonpregnant, penicillin-allergic patients 500 mg every 6 hours for 4 weeks.</p> <p>Upper respiratory tract infections 500 mg twice daily or 250 mg every 6 hours for mild to moderate infections. For severe infections, 500 mg every 6 hours. Treat streptococcal infections for 10 days.</p> <p>Lower respiratory tract infections 500 mg twice daily or 250 mg every 6 hours for mild to moderate infections. For severe infections, 500 mg every 6 hours.</p> <p>Bacterial urinary tract infection (UTI) 500 mg twice daily or 250 mg every 6 hours for mild to moderate infections. For severe infections, 500 mg every 6 hours.</p> <p>Moderate to severe acne vulgaris as adjunctive therapy 1 g/day in divided doses, then decrease slowly to 125 to 500 mg daily or every other day.</p> <p>Rocky Mountain spotted fever, Q fever, murine typhus, Rickettsial pox, and tick-bite fever caused by <i>Rickettsia</i> sp. 500 mg twice daily or 250 mg every 6 hours for mild to moderate infections. For severe infections, 500 mg every 6 hours.</p> <p>Cholera 500 mg every 6 hours for 3 days in conjunction with fluid and electrolyte replacement.</p>	<p>2 g/day is suggested by the manufacturer; 4 g/day has been recommended in some clinical practice guidelines.</p>

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.

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Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Tetracycline Hypersensitivity

IV. Dosage and Administration

- Varies by drug product. See FDA approved dosing and administration AND Appendix B.

V. Product Availability

Drug Name	Availability
Doryx MPC	Tablets (Delayed Release): 120 mg
Doxycycline Hyclate	Capsules: 50 mg, 100 mg
Doxycycline Hyclate	Capsules (Delayed-Release): 100 mg
Doxycycline Hyclate	Tablets: 20 mg, 50 mg, 75 mg, 100 mg, 150 mg
Doxycycline Hyclate	Tablets (Delayed-Release): 50 mg, 75 mg, 100 mg, 150 mg, 200 mg
Doxycycline Monohydrate	Capsules: 50 mg, 75 mg, 100 mg, 150 mg
Doxycycline Monohydrate	Capsules (Biphasic Release): 40 mg
Doxycycline Monohydrate	Tablets: 50 mg, 75 mg, 100 mg, 150 mg
Minocycline	Capsules: 50 mg, 75 mg, 100 mg
Minocycline	Tablets: 50 mg, 75 mg, 100 mg
Minocycline	Tablets (Extended Release): 45 mg, 55 mg, 65 mg, 80 mg, 90 mg, 105 mg, 115 mg, 135 mg
Minolira	Tablets (Extended Release, Biphasic Release): 105 mg, 135 mg
Nuzyra	Tablets: 150 mg
Oraxyl	Capsules: 20 mg
Seysara	Tablets: 60 mg, 100 mg, 150 mg
Tetracycline	Capsules: 250 mg, 500 mg
Vibramycin	Oral suspension: 25 mg/5 mL, 50 mg/5 mL
Ximino	Capsules (Extended Release): 45 mg, 90 mg, 135 mg

VI. References

- Doxycycline. Clinical Pharmacology. Elsevier. Tampa, FL. Available at <https://www.clinicalpharmacology-ip.com>. Accessed November 15, 2019.
- Minocycline. Clinical Pharmacology. Elsevier. Tampa, FL. Available at <https://www.clinicalpharmacology-ip.com>. Accessed November 13, 2019.
- Nuzyra (omadacycline) [package insert]. Boston, MA; Paratek Pharmaceuticals Inc.; Revised 06/2019.
- Seysara (sarecycline) [package insert]. Exton, PA; Almirall Inc.; Revised 10/2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created.	10.19	N/A
Vibramycin suspension: no PA required for age 12 or under; PA required for age above 12; added generic Doryx to PA required, non-preferred list	10.20	N/A

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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.

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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.

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