**Infectious Disease Agents: Antibiotics – Tetracyclines**

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| Criteria 1 | NP- Demeclocycline, Doxycycline 20, 40, 75, 150mg, Doxycycline DR, Minocycline IR, ER Tab, Nuzyra |
| Criteria 2 | P with AR- Doxycycline Syr, Vibramycin Susp |

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| **Criteria Title** | Infectious Disease Agents: Antibiotics – Tetracyclines | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| DEMECLOCYCLINE | 009213 | GCNSeqNo |
| DEMECLOCYCLINE | 009214 | GCNSeqNo |
| DOXYCYCLINE 20, 40, 75, 150 mg | 048077 | GCNSeqNo |
| DOXYCYCLINE 20, 40, 75, 150 mg | 072633 | GCNSeqNo |
| DOXYCYCLINE 20, 40, 75, 150 mg | 072634 | GCNSeqNo |
| DOXYCYCLINE 20, 40, 75, 150 mg | 051756 | GCNSeqNo |
| DOXYCYCLINE 20, 40, 75, 150 mg | 059845 | GCNSeqNo |
| DOXYCYCLINE 20, 40, 75, 150 mg | 060942 | GCNSeqNo |
| DOXYCYCLINE 20, 40, 75, 150 mg | 062496 | GCNSeqNo |
| DOXYCYCLINE 20, 40, 75, 150 mg | 063058 | GCNSeqNo |
| DOXYCYLINE DR | 059573 | GCNSeqNo |
| DOXYCYLINE DR | 059574 | GCNSeqNo |
| DOXYCYLINE DR | 064119 | GCNSeqNo |
| DOXYCYLINE DR | 070917 | GCNSeqNo |
| DOXYCYLINE DR | 074184 | GCNSeqNo |
| DOXYCYLINE DR | 076321 | GCNSeqNo |
| DOXYCYLINE DR | 079653 | GCNSeqNo |
| MONOCYCLINE IR, ER TAB | 009230 | GCNSeqNo |
| MONOCYCLINE IR, ER TAB | 009231 | GCNSeqNo |
| MONOCYCLINE IR, ER TAB | 052057 | GCNSeqNo |
| MONOCYCLINE IR, ER TAB | 060730 | GCNSeqNo |
| MONOCYCLINE IR, ER TAB | 060731 | GCNSeqNo |
| MONOCYCLINE IR, ER TAB | 060732 | GCNSeqNo |
| MONOCYCLINE IR, ER TAB | 065433 | GCNSeqNo |
| MONOCYCLINE IR, ER TAB | 065434 | GCNSeqNo |
| MONOCYCLINE IR, ER TAB | 066683 | GCNSeqNo |
| MONOCYCLINE IR, ER TAB | 066684 | GCNSeqNo |
| MONOCYCLINE IR, ER TAB | 066685 | GCNSeqNo |
| MONOCYCLINE IR, ER TAB | 077552 | GCNSeqNo |
| NUZYRA | 079052 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0998 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0998 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0999 |
| N | 1235 |
| 3 | 0999 |  | Select | What is the patient’s diagnosis? | Acute Infections | 1000 |
| Acne | 2000 |
| Other | 1235 |
| 4 | 1000 |  | Select and Free Text | Does the patient have an infection that is caused by an organism resistant to **ALL** preferred antibiotics?    If yes, please provide documentation of the diagnosis and any culture and sensitivity reports. | Y | END (Pending Manual Review) |
| N | 1001 |
| 5 | 1001 |  | Select | Is the patient completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility?  Please note: only the remaining course will be authorized. | Y | END (Pending Manual Review) |
| N | 1002 |
| 6 | 1002 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 3 days with at least one preferred drug?  If yes, please submit the medication trials and dates. | Y | 1004 |
| N | 1003 |
| 7 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1004 |
| N | 1236 |
| 8 | 1004 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1005 |
| N | END (Pending Manual Review) |
| 9 | 1005 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 10 | 2000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 90 days with at least one preferred oral drug for acne?  If yes, please submit the medication trials and dates. | Y | 2002 |
| N | 2001 |
| 11 | 2001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 2002 |
| N | 1236 |
| 12 | 2002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 2003 |
| N | END (Pending Manual Review) |
| 13 | 2003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 14 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment, ongoing safety monitoring, AND medical necessity for continued use? | Y | END (Pending Manual Review) |
| N | 1235 |
| 15 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 16 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Based on indication

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| **Last Approved** | 4/20/2023 |
| **Other** |  |

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| **Criteria Title** | Infectious Disease Agents: Antibiotics – Tetracyclines | | |
| **Criteria Subtitle** | Preferred Products with AR- Doxycycline Syr, Vibramycin Susp | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| DOXYCYCLINE SYR | 009217 | GCNSeqNo |
| VIBRAMYCIN SUSP | 009225 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1233 |  | Select | Is the patient 12 years and older?  Please note: a PA is only required for patients 12 years and older. | Y | 1234 |
| N | 1236 |
| 2 | 1234 |  | Select and Free Text | Is the patient able to swallow a standard tablet and/or capsule formulation?  If no, please submit documentation. | Y | 1235 |
| N | END (Pending Manual Review) |
| 3 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 4 | 1236 |  | Free Text | A PA is not required for those younger than 12 years of age. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Based on indication

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| **Last Approved** | 4/20/2023 |
| **Other** |  |