Original Effective Date: 02/2019
Current Effective Date: 02/28/2024
Last P&T Approval/Version: 01/31/2024
Next Review Due By: 01/2025
Policy Number: C8632-A

Linezolid

PRODUCTS AFFECTED

Zyvox (linezolid), linezolid

COVERAGE POLICY

Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Nosocomial pneumonia, Community-acquired pneumonia, Complicated skin and skin structure infections including diabetic foot infections without concomitant osteomyelitis, Uncomplicated skin and skin structure infections, Vancomycin-resistant Enterococcus faecium infections; Anthrax, systemic infection; health care-associated CNS infection (e.g., cerebrospinal fluid shunt infection); moderate to severe acute pulmonary exacerbation in Cystic fibrosis; Endocarditis treatment; Intracranial abscess (brain abscess, intracranial epidural abscess) and spinal epidural abscess; bacterial meningitis; Osteomyelitis and/or discitis; Prosthetic joint infection; Septic arthritis; Toxic shock syndrome; drug-resistant Tuberculosis

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by-case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area

or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

A. FOR ALL INDICATIONS:

1. Documentation member has an infection caused by or strongly suspected to be caused by a type of pathogen and site of infection within the FDA label or compendia supported
   AND
2. Prescriber attests that they have reviewed the members medication profile and the member is not concurrently taking any of the following: A) monoamine oxidase (MAO) inhibitor (e.g., phenelzine, isocarboxazid), B) selective serotonin reuptake inhibitor (SSRI), C) selective norepinephrine-reuptake inhibitor (SNRI) OR the member will discontinue the concurrent interacting medication and be monitored.
   AND
3. FOR IV LINEZOLID REQUESTS: Documentation that the member is converting from IV linezolid to oral linezolid OR documentation of medical necessity for continued IV therapy

CONTINUATION OF THERAPY:

A. FOR INDICATIONS WITH COMPENDIA APPROVED TREATMENT > 4 WEEKS ONLY:

1. Documentation member is not experiencing hematologic or neurotoxic adverse effects.
   AND
2. Prescriber attests that member is being monitored for myelosuppression and changes in vision

DURATION OF APPROVAL:

Initial authorization: 28 days; Continuation of Therapy: up to 2 months

** Linezolid is not a preferred agent for the treatment of infections requiring prolonged therapy as the risk of serious hematologic and neurologic toxicity increases after >2 weeks and >4 weeks of therapy, respectively

PRESCRIBER REQUIREMENTS:

Prescribed by or in consultation with an infectious disease specialist. [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS:

No restrictions

QUANTITY:

Dosage, frequency, and total treatment duration must be supported by FDA label or compendia supported dosing for prescribed indication

PLACE OF ADMINISTRATION:

The recommendation is that oral medications in this policy will be for pharmacy benefit coverage and patient self-administered.

The recommendation is that infused medications in this policy will be for pharmacy or medical benefit coverage administered in a place of service that is a non-inpatient hospital facility-based location.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:

Oral, Intravenous

DRUG CLASS:

Oxazolidinones

FDA-APPROVED USES:
ZYVOX is indicated in adults and children for the treatment of the following infections caused by susceptible Gram-positive bacteria:

- Nosocomial pneumonia
- Community-acquired pneumonia
- Complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis
- Uncomplicated skin and skin structure infections
- Vancomycin-resistant Enterococcus faecium infections.

Limitations of Use: ZYVOX is not indicated for the treatment of Gram-negative infections. The safety and efficacy of ZYVOX formulations given for longer than 28 days have not been evaluated in controlled clinical trials.
To reduce the development of drug-resistant bacteria and maintain the effectiveness of ZYVOX formulations and other antibacterial drugs, ZYVOX should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria.

Zyvox is indicated for the treatment of nosocomial pneumonia caused by *Staphylococcus aureus* (methicillin-susceptible and -resistant isolates) or *Streptococcus pneumoniae.*
Zyvox is indicated for the treatment of community-acquired pneumonia caused by *Streptococcus pneumoniae*, including cases with concurrent bacteremia, or *Staphylococcus aureus* (methicillin-susceptible isolates only).
Zyvox is indicated for the treatment of 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.
Zyvox is indicated for the treatment of uncomplicated skin and skin structure infections caused by *Staphylococcus aureus* (methicillin-susceptible isolates only) or *Streptococcus pyogenes.*
Zyvox is indicated for the treatment of vancomycin-resistant *Enterococcus faecium* infections, including cases with concurrent bacteremia.

COMPENDIAL APPROVED OFF-LABELED USES:
Anthrax, systemic infection; health care-associated CNS infection (e.g., cerebrospinal fluid shunt infection); moderate to severe acute pulmonary exacerbation in Cystic fibrosis; Endocarditis treatment; Intracranial abscess (brain abscess, intracranial epidural abscess) and spinal epidural abscess; bacterial meningitis; Osteomyelitis and/or discitis; Prosthetic joint infection; Septic arthritis; Toxic shock syndrome; drug-resistant Tuberculosis

APPENDIX

APPENDIX:

Reserved for State specific information. *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*

State Specific Information
State Medicaid
Ohio
Section: A. For All indications #2, “B) selective serotonin reuptake inhibitor (SSRI), C) selective norepinephrine-reuptake inhibitor (SNRI)” does NOT apply.

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
None

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:

All other uses of linezolid are considered experimental/investigational and therefore, will follow Molina's Off-Label policy. Contraindications to linezolid include: known hypersensitivity to linezolid or any of the other product components, patients taking any monoamine oxidase inhibitors (MAOI) or within two weeks of taking an MAOI.

OTHER SPECIAL CONSIDERATIONS:

Clostridioides difficile-Associated Diarrhea (CDAD) has been reported with use of nearly all antibacterial agents, including ZYVOX, and may range in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon leading to overgrowth of C. difficile. C. difficile produces toxins A and B which contribute to the development of CDAD. Hypertoxin producing strains of C. difficile cause increased morbidity and mortality, as these infections can be refractory to antimicrobial therapy and may require colectomy. CDAD must be considered in all patients who present with diarrhea following antibacterial drug use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents. If CDAD is suspected or confirmed, ongoing antibacterial drug use not directed against C. difficile may need to be discontinued. Appropriate fluid and electrolyte management, protein supplementation, antibacterial drug treatment of C. difficile, and surgical evaluation should be instituted as clinically indicated.

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

HCPCS CODE	DESCRIPTION
J2020	Injection, linezolid, 200mg
J2021	Injection, linezolid (hospira) not therapeutically equivalent to J2020, 200 mg

AVAILABLE DOSAGE FORMS:

Linezolid in Sodium Chloride SOLN 600-0.9MG/300ML-%
Linezolid SOLN 600MG/300ML
Linezolid SUSR 100MG/5ML
Linezolid TABS 600MG
Zyvox SOLN 200MG/100ML
Zyvox SOLN 600MG/300ML
Zyvox SUSR 100MG/5ML
Zyvox TABS 600MG

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SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Diagnosis Required Medical Information Continuation of Therapy Compendial Approved Off-Labeled Uses Other Special Considerations References	Q1 2024
REVISION- Notable revisions: Products Affected Required Medical Information Continuation of Therapy FDA-Approved Uses Contraindications/Exclusions/Discontinuation Coding/Billing Information Available Dosage Forms References	Q1 2023
Q2 2022 Established tracking in new format	Historical changes on file