Effective Date: 08/01/2018
Last P&T Approval/Version: 01/26/2022
Next Review Due By: 01/2023
Policy Number: C14575-A

Vibativ (telavancin)

PRODUCTS AFFECTED

Vibativ (telavancin)

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:
Complicated skin and skin structure infections (cSSSI), Hospital-acquired and ventilator-associated bacterial pneumonia (HABP/VABP) caused by susceptible isolates of Staphylococcus aureus , Staphylococcus aureus (MRSA) bacteremia (off-label)

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

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. (a) Documentation of FDA labeled contraindication to Vancomycin
   OR
   (b) Documentation of inadequate treatment response, intolerance, or non-susceptibility report for the current infection to Vancomycin
   OR
   (c) Prescriber provides detailed medical necessity rationale against outpatient parenteral antimicrobial therapy with Vancomycin
   OR
   (d) Request is for a continuation of therapy that was started at an in-patient setting (within the last 14 days) and member is at time of request transitioning to an outpatient site of care [DISCHARGE DOCUMENTATION REQUIRED WHICH INCLUDES INFECTIOUS DISEASE PRESCRIBER, DURATION OF THERAPY; START AND END DATE]

CONTINUATION OF THERAPY:
NA

DURATION OF APPROVAL:
Initial authorization: Complicated skin and skin structure infections (cSSSI): 14 days,
Hospital- acquired and ventilator-associated bacterial pneumonia (HABP/VABP): 21 days.
Continuation of Therapy: N/A

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

AGE RESTRICTIONS:
18 years of age or older

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 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:
Intravenous Infusion

DRUG CLASS:
Anti-Infective Agents - Misc.

FDA-APPROVED USES:
VIBATIV is indicated for the treatment of the following infections in adult patients caused by designated susceptible bacteria:
• Complicated skin and skin structure infections (cSSSI)
• Hospital-acquired and ventilator-associated bacterial pneumonia (HABP/VABP) caused by susceptible isolates of Staphylococcus aureus.
VIBATIV should be reserved for use when alternative treatments are not suitable.
To reduce the development of drug-resistant bacteria and maintain the effectiveness of VIBATIV and other antibacterial drugs VIBATIV should only be used to treat or prevent infections that are proven

or strongly suspected to be caused by bacteria

COMPENDIAL APPROVED OFF-LABELED USES:
Bacteremia due to S. aureus

APPENDIX

APPENDIX:
None

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
None

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Vibativ (telavancin) are considered experimental/investigational and therefore, will follow Molina's Off-Label policy. Contraindications to Vibativ (telavancin) include hypersensitivity to telavancin or any component of the formulation, concomitant use of intravenous unfractionated heparin

BLACK BOX WARNING: INCREASED MORTALITY IN HABP/VABP PATIENTS WITH PRE-EXISTING MODERATE OR SEVERE RENAL IMPAIRMENT, NEPHROTOXICITY, and EMBRYOFETAL TOXICITY

OTHER SPECIAL CONSIDERATIONS:
None

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
J3095	Injection, telavancin, 10mg

AVAILABLE DOSAGE FORMS:
Vibativ Inj 250MG, Vibativ Inj 750MG

REFERENCES

1. Vibativ (telavancin) [prescribing information]. Nashville, TN: Cumberland Pharmaceuticals Inc; December 2020
2. Stryjewski ME, O'Riordan WD, Lau WK, et al, "Telavancin Versus Standard Therapy for Treatment of Complicated Skin and Soft-Tissue Infections Due to Gram-Positive Bacteria," Clin Infect Dis, 2005, 40(11):1601-7

3. Rubinstein E, Lalani T, Corey GR, et al, “Telavancin versus Vancomycin for Hospital-Acquired Pneumonia Due to Gram-Positive Pathogens,” Clin Infect Dis, 2011, 52(1):31-40.
4. Liu C, Bayer A, Cosgrove SE, et al, “Clinical Practice Guidelines by the Infectious Diseases Society of America for the Treatment of Methicillin-Resistant Staphylococcus Aureus Infections in Adults and Children: Executive Summary,” Clin Infect Dis, 2011, 52(3):285-92.
5. Wilson SE, O’Riordan W, Hopkins A, et al, “Telavancin Versus Vancomycin for the Treatment of Complicated Skin and Skin-Structure Infections Associated With Surgical Procedures,” Am J Surg, 2009, 197(6):791-6.
6. Stryjewski ME, Lentnek A, O'Riordan W, et al. A randomized Phase 2 trial of telavancin versus standard therapy in patients with uncomplicated Staphylococcus aureus bacteremia: the ASSURE study. BMC Infect Dis. 2014;14:289
7. “Guidelines for the Management of Adults with Hospital-Acquired, Ventilator-Associated, and Healthcare-Associated Pneumonia.” American Journal of Respiratory and Critical Care Medicine, vol. 171, no. 4, 2005, pp. 388–416., doi:10.1164/rccm.200405-644st.