April 14, 2017

Provider Memorandum

Responsible Prescribing of Antibiotics in Pediatrics with Upper Respiratory Infections

Molina Healthcare of Illinois (Molina) is committed to provide quality service to our Members.

The table below outlines the Centers of Disease Control and Prevention guidance on appropriate antibiotics prescribing for children obtaining care in an outpatient setting for upper respiratory (URTI) diagnosis (2017).

Common Cold or non-specific URTI	Pharyngitis	Acute Otitis Media (AOM)	Acute Sinusitis
• Management of the common cold, nonspecific URI, and acute cough illness should focus on symptomatic relief. Antibiotics should not be prescribed for these conditions. • There is potential for harm and no proven benefit from over-the-counter cough and cold medications in children 6 years and younger. These substances are among the top 20 substances leading to death in children younger than 5 years. • Low-dose inhaled corticosteroids and oral prednisolone do not improve outcomes in children without asthma.	• Amoxicillin and penicillin V remain first-line therapy. • For children with a non-type I hypersensitivity to penicillin: cephalexin, cefadroxil, clindamycin, clarithromycin, or azithromycin are recommended. • For children with an immediate type I hypersensitivity to penicillin: clindamycin, clarithyomycin, or azithromycin are recommended. • Recommended treatment course for all oral beta lactams is 10 days.	• Mild cases with unilateral symptoms in children 6-23 months of age or unilateral or bilateral symptoms in children older than 2 years may be appropriate for watchful waiting based on shared decision-making. • Amoxicillin remains first line therapy for children who have not received amoxicillin within the past 30 days. • Amoxicillin/clavulanate is recommended if amoxicillin has been taken within the past 30 days, if concurrent purulent conjunctivitis is present, or if the child has a history of recurrent AOM unresponsive to amoxicillin. • For children with a non-type I hypersensitivity to penicillin: cefdinir, cefuroxime, cefpodoxime, or ceftriaxone may be appropriate choices. • Prophylactic antibiotics are not recommended to reduce the frequency of recurrent AOM.	If a bacterial infection is established: • Watchful waiting for up to three days may be offered for children with acute bacterial sinusitis with persistent symptoms. Antibiotic therapy should be prescribed for children with acute bacterial sinusitis with severe or worsening disease. • Amoxicillin or amoxicillin/clavulanate remain first-line therapy. • Recommendations for treatment of children with a history of type I hypersensitivity to penicillin vary. • In children who are vomiting or who cannot tolerate oral medication, a single dose of ceftriaxone can be used and then can be switched to oral antibiotics if improving.

Molina values and appreciates the services you provide to our Members. Thank you for working together with us and for your continued support.

Please contact your Provider Services Representatives if you have questions or need guidance. You may also contact the Provider Service Department at (630) 203-3965 or via email at IllinoisProviders@MolinaHealthcare.com.

References

Centers for Disease Control and Prevention. (2017). Pediatric Treatment Recommendations. Retrieved from https://www.cdc.gov/getsmart/community/for-hcp/outpatient-hcp/pediatric-treatment-rec.html