**Nevada Medicaid Drug Use Review Board Votes to Adopt Policy on Outpatient Antibiotic Medications**

The Nevada Medicaid Drug Use Review (DUR) Board met on July 26, 2018, and voted to adopt prior authorization criteria for third-generation cephalosporins, fluoroquinolones and oxazolidinones antibiotics. The criteria and requirements follow.

Effective March 4, 2019, the following third-generation cephalosporins, fluoroquinolones and oxazolidinones will require prior authorization for outpatient pharmacy claims.

<table>
<thead>
<tr>
<th>3rd Generation Cephalosporins</th>
<th>Fluoroquinolones</th>
<th>Oxazolidinones</th>
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<tr>
<td>Cefdinir</td>
<td>Ciprofloxacin</td>
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<td>Cefixime</td>
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<td>Cefpodoxime</td>
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<td>Ceftazidime</td>
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<td>Ceftriaxone</td>
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**Third Generation Cephalosporin and Fluoroquinolone Criteria:**

Prior authorization (PA) will be approved for the third-generation cephalosporins and fluoroquinolones if culture and sensitivity-proven susceptibilities and resistance to other agents suggest the requested drug is necessary.

**Oxazolidinone Criteria:**

Prior authorization for Sivextro® (tedizolid) will be approved for recipients with a diagnosis of acute bacterial skin and skin structure infection:

- If the infection is caused by methicillin-resistant Staphylococcus aureus (MRSA), and
- The recipient has had a trial of or has a contraindication to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection or culture or local sensitivity patterns; examples of alternative antibiotics may include, but not limited to: TMP/SMX, doxycycline, vancomycin, daptomycin, talavancin, clindamycin).

Prior authorization for Zyvox® (linezolid) will be approved:

- If the recipient has a diagnosis of vancomycin-resistant enterococcus (VRE) faecium infection or a diagnosis of MRSA infection, and
• The recipient has had a trial of or has a contraindication to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns; examples of alternative antibiotics may include, but are not limited to: TMP/SMX, doxycycline, vancomycin, tetracycline, clindamycin).

Approval will be granted if the recipient started treatment with intravenous antibiotic(s) in the hospital and requires continued outpatient therapy.

Exception criteria:

• Prescribed by an infectious disease specialist or by an emergency department provider.
• Ceftriaxone prescribed as first line treatment for gonorrhea, pelvic inflammatory disease, epididymo-orchitis and is an alternative to benzylpenicillin to treat meningitis for those with severe penicillin allergy.
• If cefixime is prescribed for gonococcal infection where ceftriaxone is unavailable.
• The recipient resides in one of the following:
  o Acute Care
  o Long-term Acute Care (LTAC)
  o Skilled Nursing Facility (SNF)

Pharmacy override at Point of Sale:

Pharmacies are able to bypass PA requirements if the prescriber is verified as an infectious disease specialist or an emergency department provider. The pharmacy must enter a PA Type “01” and PA Number of “00000054321”.