CareFirst Family of health care plans

CVS caremark™

STEP THERAPY CRITERIA

BRAND NAME
(generic)

FIRVANQ
(vancomycin)

VANCOCIN
(vancomycin capsules)

Status: CVS Caremark Criteria
Type: Initial Step Therapy with Qty Limit;
Post Step Therapy Prior Authorization with Qty Limit

POLICY

FDA-APPROVED INDICATIONS

Vancocin

Vancocin capsules are indicated for the treatment of C. difficile-associated diarrhea. Vancocin capsules are also used for the treatment of enterocolitis caused by Staphylococcus aureus (including methicillin-resistant strains). Parenteral administration of vancomycin is not effective for the above infections; therefore, Vancocin capsules must be given orally for these infections.

Firvanq

Firvanq is indicated for the treatment of *Clostridium difficil*e-associated diarrhea in adults and pediatric patients less than 18 years of age.
Firvanq is also indicated for the treatment of enterocolitis caused by *Staphylococcus aureus* (including methicillin-resistant strains) in adults and pediatric patients less than 18 years of age.

Limitations of Use

- Parenteral administration of vancomycin is not effective for the above infections; therefore, vancomycin must be given orally for these infections.
- Orally administered vancomycin hydrochloride is not effective for treatment of other types of infections.

INITIAL STEP THERAPY with QUANTITY LIMIT*

If the patient has filled a prescription for at least a 10 day supply of metronidazole OR at least a 7 day supply of Vancocin (vancomycin hydrochloride capsules), or at least a 7 day supply of Firvanq (vancomycin hydrochloride powder for oral solution) OR a 10 day supply of Dificid within the past 60 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.* If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.
***For patients who meet the Initial Step, the quantity for approval will be 80 Vancocin capsules OR**

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450 mL Firvanq solution.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- Patient has enterocolitis caused by *Staphylococcus aureus*

OR

- Patient has *Clostridium difficil*e-associated diarrhea
  AND
- Has experienced an inadequate treatment response to metronidazole after a trial of at least 10 days OR has intolerance or contraindication to metronidazole OR is not a candidate for treatment with metronidazole, (e.g., severe *C. difficile* infection, second recurrence)

Quantity Limits apply.

REFERENCES

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5. Cohen S, Gerding D, Johnson S, et al. Clinical Practice Guidelines for Clostridium difficile Infection in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA). *Infection Control and Hospital Epidemiology* 2010; 31:431-455.
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7. Centers for Disease Control. Clostridium difficile Infection. Available at http://www.cdc.gov/HAI/organisms/cdiff/Cdiff_infect.html. Accessed December 2017.
8. Gould C, McDonald C. Bench-to-bedside review: Clostridium difficile colitis. *Critical Care* 2008; 12:203-211.
9. Safety and Efficacy of Fidaxomicin in the Treatment of *Clostridium Difficile*-associated Diarrhea. Available at http://www.medscape.com/viewarticle/774585_1-10. Accessed December 2017.