

Clinical Policy Title:	metronidazole
Policy Number:	RxA.241
Drug(s) Applied:	Nuvessa™
Original Policy Date:	02/07/2020
Last Review Date:	01/01/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Bacterial Vaginosis (must meet all):

1. Diagnosis of bacterial vaginosis;
2. Trial of metronidazole 0.75% vaginal gel, unless contraindicated or clinically significant adverse effects are experienced;

Approval Duration

All Lines of Business (except Medicare): 1 month

II. Continued Therapy Approval

A. Bacterial Vaginosis:

1. Re-authorization is not permitted. Member must meet the initial approval criteria.

Approval Duration

All Lines of Business (except Medicare) Not applicable

References

Not Applicable

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established	01/2020	02/07/2020
Policy was reviewed: <ol style="list-style-type: none"> 1. Clinical Policy Title was updated. 2. Drug(s) Applied was updated. 3. Line of Business Policy Applies to was update to all lines of business. 4. Initial Approval criteria: Commercial and Medicaid approval duration were updated to 1 months. 5. References were updated. 	07/20/2020	09/14/2020
Policy was reviewed: <ol style="list-style-type: none"> 1. References were updated. 	03/08/2021	06/10/2021
Policy was reviewed: <ol style="list-style-type: none"> 1. Clinical Policy Title: Updated from 	01/19/2022	04/18/2022

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

<p>"metronidazole vaginal gel" to "metronidazole".</p> <p>2. References were reviewed and updated.</p>		
<p>Policy was reviewed:</p> <p>1. Initial Approval Criteria, I.A.4: Updated to "Failure of..." from "Documentation supports inability to use..."</p>	6/25/2022	7/18/2022
<p>Policy was reviewed:</p> <p>1. Removed prior age criteria.</p> <p>2. Removed requirement of member not being pregnant.</p> <p>3. Removed prior dosing criteria.</p> <p>4. Updated approval duration.</p> <p>5. References were reviewed and updated.</p>	12/12/2023	01/01/2024