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: 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: 1. References were updated.	03/08/2021	06/10/2021
Policy was reviewed: 1. Clinical Policy Title: Updated from	01/19/2022	04/18/2022

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