I. Policy:
Zerbaxa (ceftolozane/tazobactam)

II. Purpose/Objective:
To provide a policy of coverage regarding Zerbaxa (ceftolozane/tazobactam)

III. Responsibility:
A. Medical Directors
B. Medical Management
C. Pharmacy Department

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards good medical treatment practiced by the general medical community;
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and

e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) the service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

(ii) the service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.

(iii) the service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.
DESCRIPTION:
Zerbaxa (ceftolozane/tazobactam) is a cephalosporin combination. Ceftolozane inhibits bacterial cell wall synthesis by binding to one or more of the penicillin-binding proteins (PBPs); which in turn inhibits the final transpeptidation step of peptidoglycan synthesis in bacterial cell walls, thus inhibiting cell wall biosynthesis. Ceftolozane is an inhibitor of PBPs of Pseudomonas aeruginosa (eg, PBP1b, PBP1c, and PBP3) and Escherichia coli (eg, PBP3). Tazobactam irreversibly inhibits some beta-lactamases (eg, certain penicillinases and cephalosporinases), and can covalently bind to some plasmid-mediated and chromosomal bacterial beta-lactamases.

CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee

Zerbaxa (ceftolozane/tazobactam) will be considered medically necessary when ALL of the following criteria are met:

- Prescription is written by or in consultation with Infectious Disease AND
- Medical record documentation that the member is greater than or equal to 18 years of age AND
- Medical record documentation of one of the following:
  - Diagnosis of Complicated Intra-abdominal Infection (cIAI) caused by: Enterobacter cloacae, Escherichia coli, Klebsiella oxytoca, Klebsiella pneumoniae, Proteus mirabilis, Pseudomonas aeruginosa, Bacteroides fragilis, Streptococcus anginosus, Streptococcus constellatus, or Streptococcus salivarius OR
  - Diagnosis of Complicated Urinary Tract Infection (including Pyelonephritis) (cUTI) caused by Escherichia coli, Klebsiella pneumoniae, Proteus mirabilis, or Pseudomonas aeruginosa OR
  - Diagnosis of Hospital-acquired Bacterial Pneumonia or Ventilator-associated Bacterial Pneumonia (HABP/VABP) caused by Enterobacter cloacae, Escherichia coli, Haemophilus influenzae, Klebsiella oxytoca, Klebsiella pneumoniae, Proteus mirabilis, Pseudomonas aeruginosa, or Serratia marcescens. AND
- Medical record documentation of a culture and sensitivity showing the patient’s infection is not susceptible to preferred alternative antibiotic treatments OR a documented history of previous intolerance to or contraindication to three (3) preferred alternative antibiotics shown to be susceptible on the culture and sensitivity

AUTHORIZATION DURATION:
For cUTI: 7 days
For cIAI or HABP/VABP: up to 14 days

QUANTITY LIMITS:

For cUTI: MedAccess: 3 vials per day, Facets RX Count: 420 units
For cIAI: MedAccess 3 vials per day, Facets RX Count: 840 units
For HABP/VABP: 6 vials per day, Facets RX Count: 1680 units

LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy.

This policy will be revised as necessary and reviewed no less than annually.

Devised: 11/19/19

Revised: 

Reviewed: