Clinical Policy: Levofloxacin in Pediatric Community Acquired Pneumonia
Reference Number: GA.PMN.05
Effective Date: 03/01/16
Last Review Date: 2/19
Line of Business: Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The intent of the criteria is to ensure that patients follow selection elements established by Centene® medical policy for the use of Levofloxacin (Levaquin®) in pediatric patients older than 3 months of age for community acquired pneumonia.

FDA Approved Indication(s)
Levquin is indicated for the treatment of:
- Pneumonia: nosocomial and community acquired
- Acute bacterial sinusitis
- Acute bacterial exacerbation of chronic bronchitis
- Skin and skin structure infections: complicated and uncomplicated
- Chronic bacterial prostatitis
- Urinary tract infections: complicated and uncomplicated
- Acute pyelonephritis

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Levaquin is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Community Acquired Pneumonia (must meet all):
      1. Diagnosis of community acquired pneumonia;
      2. Prescribed by or in consultation with a physician;
      3. Member meets one of the following (a or b):
         a. Documentation of Georgia Registry of Immunization Transactions and Services (GRITS) status if not fully immunized to H. Influenzae and/or S. Pneumoniae;
         b. Failure of 10 days trial of Amoxicillin or Amoxicillin/Clavulanate unless contraindicated or clinically significant adverse effects are experienced;
      4. Dose does not exceed:
         a. Age 6 months to 5 years old: 16-20 mg/kg/day divided in 2 doses. Max: 750mg/day;
         b. Age 5-16 years old: 8-10 mg/kg/day once daily. Max: 750mg/day.
   Approval duration: up to 10 days
B. Other diagnoses/indications:
Not applicable

II. Continued Therapy
A. Community Acquired Pneumonia
1. Authorization for additional days must be reviewed by the plan on a case by case basis.
   Approval duration: Not applicable

B. Other diagnoses/indications:
Not applicable

III. Diagnoses/Indications for which coverage is NOT authorized:
Not applicable

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
GRITS: Georgia Registry of Immunization Transactions and Services

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin (Amoxil®)</td>
<td>Lower respiratory tract 45 mg/kg/day in divided doses every 12 hours or 40 mg/kg/day in divided doses every 8 hours</td>
<td>90 mg/kg/day</td>
</tr>
<tr>
<td>Amoxicillin/Clavulanate potassium (Augmentin®)</td>
<td>Lower respiratory tract 45 mg/kg/day in divided doses every 12 hours or 40 mg/kg/day in divided doses every 8 hours</td>
<td>90 mg/kg/day</td>
</tr>
</tbody>
</table>

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: General Information
Pneumonia is a lower respiratory tract infection. It is the single greatest cause of death in children worldwide. Community Acquired Pneumonia (CAP) in children is defined as the presence of signs and symptoms in a previously healthy child caused by an infection that has been acquired outside of the hospital. Viruses and bacteria can be responsible for CAP in children. Before the widespread use of *H. Influenzae* and *S. Pneumoniae* vaccines, *S. Pneumoniae* was documented as the most common bacterial pathogen. Usual atypical pathogens include *M. pneumoniae* commonly in older children and *C. pneumonia* in infants. Since viral pathogens are common in pre-school aged children with CAP, antimicrobial therapy is not usually warranted for this population. High-dose Amoxicillin (90mg/kg/day)
or Augmentin is recommended as first-line treatment for pre-school and school aged children and adolescents who are previously healthy and appropriately immunized with mild to moderate CAP since it provides coverage for *S. Pneumoniae*. When atypical pathogens are suspected then macrolides or doxycycline can be tried or added to penicillin therapy. In penicillin allergic patients clindamycin, levofloxacin, linezolid, or macrolides (resistance may be high) may be appropriate. For mild allergic reactions, another trial of amoxicillin or a cephalosporin (i.e., Cefpodoxime, Cefprozil, cefuroxime) with activity against *S. Pneumoniae* under medical supervision might be beneficial. No oral cephalosporin at doses studied in children provides activity at the site of infection that equals high-dose amoxicillin. Second and third generation cephalosporins generally only provide activity against 60%-70% of current isolates of pneumococcus. Alternatively clindamycin provides activity against 60%-85% pneumococcal strains and Levofloxacin and Linezolid provide activity against >95% of strains. Careful selection with patient variability and infection characteristics is prudent.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
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<tr>
<td>Community acquired pneumonia</td>
<td>• Age 6 months to 5 years old: 16-20 mg/kg/day divided in 2 doses&lt;br&gt;• Age 5-16 years old: 8-10 mg/kg/day once daily</td>
<td>750 mg/day</td>
</tr>
</tbody>
</table>

VI. Product Availability

- Tablets: 250mg, 500mg, 750mg
- Oral Solution: 25 mg/ml

VII. References

1. Bradley et al. The Management of Community-Acquired Pneumonia in Infants and Children Older than 3 months of Age: Clinical Practice Guidelines by the Pediatric Infectious Diseases Society and the Infectious Diseases Society of America not use UpToDate

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>Policy created</td>
<td>03.01.16</td>
<td>03.16</td>
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<tr>
<td>1Q 2017 annual review: no significant changes</td>
<td>01.01.17</td>
<td>01.17</td>
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<tr>
<td>1Q 2018 annual review: no significant changes</td>
<td>01.01/18</td>
<td>01.18</td>
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<tr>
<td>Changed current Georgia policy templates to corporate standard templates for drug coverage criteria to meet corporate compliance. Changes/revisions included; new formatting, font size, use of standard policy language for each section of policy, and rearranged order of certain steps in criteria and sections.</td>
<td>2/21/19</td>
<td></td>
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Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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