

## Clinical Policy: Metronidazole Vaginal Gel (Nuessa)

Reference Number: CP.CPA.132

Effective Date: 11.16.16

Last Review Date: 11.19

Line of Business: Commercial

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Metronidazole vaginal gel (Nuessa™) is a nitroimidazole antimicrobial.

### FDA Approved Indication(s)

Nuessa is indicated for the treatment of bacterial vaginosis in females 12 years of age and older.

### 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 Nuessa is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Bacterial Vaginosis (must meet all):

1. Diagnosis of bacterial vaginosis;
2. Age  $\geq$  12 years;
3. Member is not pregnant;
4. Documentation supports inability to use metronidazole 0.75% vaginal gel;
5. Dose does not exceed one applicator as a single dose.

**Approval duration: 1 month (one dose)**

##### B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial.

#### II. Continued Therapy

##### A. Bacterial Vaginosis

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

**Approval duration: Not applicable**

##### B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy;

**Approval duration: Duration of request or 1 month (whichever is less); or**

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial.

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

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.CPA.09 or evidence of coverage documents

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

*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.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
metronidazole gel 0.75% (MetroGel-Vaginal, Vandazole)	One applicatorful (~37.5 mg) intravaginally QD to BID for 5 days	2 applicators/day

*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: Contraindications/Boxed Warnings*

- Contraindication(s):
  - History of hypersensitivity to metronidazole, parabens, other ingredients of the formulation, or other nitroimidazole derivatives
  - Concomitant use of disulfiram or within 2 weeks of disulfiram
  - Concomitant use of alcohol
- Boxed warning(s): none reported

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Bacterial vaginosis in non-pregnant women	One applicator of 5 g of gel (65 mg of metronidazole) administered intravaginally as a single dose at bedtime	1 applicator/day

**VI. Product Availability**

Prefilled applicator: 1.3% gel (5 g of vaginal gel containing approximately 65 mg of metronidazole)

**VII. References**

1. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed August 13, 2019.
2. Nuessa Prescribing Information. Florham Park, NJ: Exeltis USA, Inc.; August 2018. Available at: <http://www.nuessa.com>. Accessed on August 13, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted to new template. Minor changes to verbiage and grammar. References updated.	01.19.17	11.17
4Q 2018 annual review: no significant changes; added age limit; change approval durations from length of benefit and altered wording for continued therapy to reflect the one-time use nature of this agent; references reviewed and updated.	07.16.18	11.18
4Q 2019 annual review: no significant changes; revised approval duration to 1 month for one-time use; revised continuation therapy section to state that re-authorization is not permitted and new cases/recurrences must be reviewed under initial therapy criteria; references reviewed and updated.	08.13.19	11.19

**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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