Clinical Policy: Metronidazole Vaginal Gel (Nuvessa)

Reference Number: CP.CPA.132
Effective Date: 11.16.16
Last Review Date: 11.24
Line of Business: Commercial

Revision Log

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

Description
Metronidazole 1.3% vaginal gel (Nuvessa®) is a nitroimidazole antimicrobial.

FDA Approved Indication(s)
Nuvessa 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 Nuvessa 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 ≥ 12 years;
3. Member must use metronidazole 0.75% vaginal gel, unless contraindicated or clinically significant adverse effects are experienced, or documentation supports necessity of metronidazole 1.3% vaginal gel;
4. Dose does not exceed one applicator as a single dose.

Approval duration: 1 month (one dose)

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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 for commercial 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% (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	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. Nuvessa Prescribing Information. Florham Park, NJ: Exeltis USA, Inc.; February 2022. Available at: http://www.nuvessa.com. Accessed July 25, 2024.
2. Clinical Pharmacology [database online]. Tampa, FL: Elsevier, Inc.; 2024. Available at: https://www.clinicalkey.com/pharmacology/. Accessed July 25, 2023.
3. Workowski KA, Bachmann LH, Chan PA, et al. Sexually transmitted infections treatment guidelines, 2021. *MMWR Recomm Rep.* 2021 Jul 23;70(4):1-187. doi: 10.15585/mmwr.rr7004a1.
4. ACOG practice bulletin, number 215: Vaginitis in nonpregnant patients. *Obstetrics and Gynecology*. 2020; 135(1): 243-245.
5. Paladine HL, Desai UA. Vaginitis: Diagnosis and Treatment. *Am Fam Physician*. 2018 Mar 1;97(5):321-329.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2020 annual review: removed criteria: member is not pregnant; references reviewed and updated.	07.29.20	11.20
4Q 2021 annual review: no significant changes; revised from "documentation supports inability" to "must use"; references reviewed and updated.	07.02.21	11.21
4Q 2022 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications.	08.27.22	11.22
4Q 2023 annual review: no significant changes; references reviewed and updated.	06.28.23	11.23
4Q 2024 annual review: no significant changes; removed commercially unavailable brand therapeutic alternatives; references reviewed and updated.	07.12.24	11.24

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.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.