Tetracyclines (oral)

Policy # 00341
Original Effective Date: 02/20/2013
Current Effective Date: 04/19/2017

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the “Company”), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- Benefits are available in the member’s contract/certificate, and
- Medical necessity criteria and guidelines are met.

Based on review of available data, the Company may consider brand name oral tetracyclines including, but not limited to Dclomycin®‡ (demeclocycline), Adoxa®‡ (doxycycline), Doryx®‡ (doxycycline hyclate), Vibramax®‡ (doxycycline hyclate), Solodyn®‡ (minocycline), and Sumycin®‡ (tetracycline) to be eligible for coverage when ONE of the below patient selection criteria is met:

Patient Selection Criteria
Coverage eligibility will be considered for brand name oral tetracyclines when ONE of the following criteria is met:

- The patient has tried and failed one generic oral tetracycline (e.g. demeclocycline, doxycycline, minocycline, tetracycline); OR
- There is clinical evidence or patient history that suggests the generically available products will be ineffective or cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary
Based on review of available data, the Company considers the use of brand name oral tetracyclines when patient selection criteria are not met or for usage not included in the above patient selection criteria to be not medically necessary.**

Background/Overview
Demeclocycline, doxycycline, minocycline, and tetracycline are broad spectrum oral antibiotic agents. In general, these medications are all Food and Drug Administration (FDA)-indicated to treat a wide variety of infections such as those caused by gram negative and positive microorganisms; in adjunct to other therapies for severe acne; and in situations where penicillin is contraindicated due to allergy.

Rationale/Source
The patient selection criteria presented in this policy takes into consideration clinical evidence or patient history that suggests the generically available products will be ineffective or cause an adverse reaction to the patient. Based on a review of the data, in the absence of the above mentioned caveat, there is no advantage of using a brand name oral tetracycline over the available generic oral tetracyclines.Generic drugs are considered to have equal bioavailability and efficacy in comparison to brand name drugs.

References
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10. Oracea™ capsules [prescribing information]. Fort Worth, TX: Galderma Laboratories, LP; July 2013.
11. Solodyn film coated, extended release tablet [prescribing information]. Scottsdale, AZ: Medicis; February 2012.

Policy History
Original Effective Date: 02/20/2013
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02/07/2013 Medical Policy Committee review
02/20/2013 Medical Policy Implementation Committee approval. New policy.
02/06/2014 Medical Policy Committee review
02/19/2014 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
04/02/2015 Medical Policy Committee review
04/20/2015 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
04/07/2016 Medical Policy Committee review
04/20/2016 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
04/06/2017 Medical Policy Committee review
04/19/2017 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 04/2018

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
A. In accordance with nationally accepted standards of medical practice;
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B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and

C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.