

Pharmacy Policy Bulletin

Title: Retapamulin (Altabax®)

Policy #: Rx.01.79

Application of pharmacy policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Some medications may be subject to precertification, age, gender or quantity restrictions. Individual member benefits must be verified.

This pharmacy policy document describes the status of pharmaceutical information and/or technology at the time the document was developed. Since that time, new information relating to drug efficacy, interactions, contraindications, dosage, administration routes, safety, or FDA approval may have changed. This Pharmacy Policy will be regularly and updated as scientific and medical literature becomes available. This information may include new FDA-approved indications, withdrawals, or other FDA alerts. This type of information is relevant not only when considering whether this policy should be updated, but also when applying it to current requests for coverage.

Members are advised to use participating pharmacies in order to receive the highest level of benefits.

▶ Intent:

Retapamulin (Altabax®) is a topical antibiotic indicated for the treatment of impetigo due to Staphylococcus aureus (methicillin-susceptible isolates only) or Streptococcus pyogenes in individuals nine months of age and older.

The use of retapamulin (Altabax®) requires prior authorization (i.e. clinical pharmacy and/or Medical Director review).

▶ Description:

Retapamulin (Altabax®) is the first in a new class of antibiotics called pleuromutilins. Retapamulin (Altabax®) inhibits bacterial protein synthesis by interacting with the 50S subunit of the bacterial ribosome.

▶ Policy:

Retapamulin (Altabax®) is approved when all of the following inclusion criteria are met:

- Documented diagnosis of impetigo in individuals 9 months of age or older
- Documentation of a trial and failure of/contraindication/intolerance/allergy to mupirocin ointment

▶ Guidelines:

Refer to the specific manufacturer's prescribing information for administration and dosage details and any applicable Black Box warnings.

BENEFIT APPLICATION

Subject to the terms and conditions of the applicable benefit contract, the applicable drug(s) identified in this policy is (are) covered under the pharmacy benefits of the Company's products when the medical necessity criteria listed in this pharmacy policy are met. Any services that are experimental/investigational or cosmetic are benefit contract exclusions for all products of the Company.

▶ References:

Altabax [package insert]. Research Triangle Park, NC: GlaxoSmithKline; 2010.

Gilbert DN, Moellering RC, Eliopoulos GM, Dande MA. Sanford Guide to Antimicrobial Therapy 2006. 36th ed. Hyde Park, VT: Antimicrobial Therapy, Inc.; 2006.


Mupirocin 2% ointment [package insert]. Bronx, NY: Clay-Park Labs; 2007.

Retapamulin (Altabax®). In: Drugdex [online through Micromedex Healthcare Series]. Greenwood Village, CO: Thomson Micromedex. Accessed December 30, 2011.

Retapamulin (Altabax®). In: Facts and Comparisons [online through Facts and Comparisons Online]. Indy, IN: Walter Kluwer Health Inc. Accessed December 30, 2011.

Stevens DL, Bisno AL, Chambers HF, et al. Practice guidelines for the diagnosis and management of skin and soft tissue infections. *Clin Infect Dis*. 2005;41(10):1373-1406.

 **Applicable Drugs:**

 Inclusion of a drug in this table does not imply coverage. Eligibility, benefits, limitations, exclusions, precertification/referral requirements, provider contracts, and Company policies apply.

Brand Name	Generic Name
Altabax	retapamulin

 **Cross References:**

Policy Version Number: 1.00
P&T Approval Date: November 10, 2011
Policy Effective Date: February 01, 2012
Next Required Review Date: November 10, 2012

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