

Policy: MBP 132.0

Section: Medical Benefit Pharmaceutical Policy

Subject: Avycaz (cefazidime/avibactam)

I. Policy:

Avycaz (cefazidime/avibactam)

II. Purpose/Objective:

To provide a policy of coverage regarding Avycaz (cefazidime/avibactam)

III. Responsibility:

- A. Medical Directors
- B. Medical Management
- C. Pharmacy Department

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than
3. the department requiring/authoring the policy.
4. Devised – the date the policy was implemented.
5. Revised – the date of every revision to the policy, including typographical and grammatical changes.
6. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards good medical treatment practiced by the general medical community;
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient

Medicaid Business Segment

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) the service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) the service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) the service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age

DESCRIPTION:

Avycaz (cefazidime/avibactam) is a combination cephalosporin/beta-lactamase inhibitor indicated in combination with metronidazole, for the treatment of complicated intra-abdominal infections (cIAI) caused by the following susceptible microorganisms: *Escherichia coli*, *Klebsiella pneumoniae*, *Proteus mirabilis*, *Enterobacter cloacae*, *Klebsiella oxytoca*, *Citrobacter freundii* complex and *Pseudomonas aeruginosa* in patients 3 months or older.

Avycaz is also indicated for the treatment of complicated urinary tract infections (cUTI) including pyelonephritis caused by the following susceptible microorganisms: *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Citrobacter freundii* complex, *Proteus mirabilis*, and *Pseudomonas aeruginosa* in patients 3 months or older.

CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee

Avycaz (cefazidime/avibactam) will be considered medically necessary when all of the following criteria are met:

- Prescribed by or in consultation with an infectious disease specialist AND
- Medical record documentation of one of the following:
 - A diagnosis of complicated intra-abdominal infection caused by caused by the following susceptible microorganisms: *Escherichia coli*, *Klebsiella pneumoniae*, *Proteus mirabilis*, *Enterobacter cloacae*, *Klebsiella oxytoca*, *Citrobacter freundii* complex and *Pseudomonas aeruginosa* **OR**
 - A diagnosis of complicated urinary tract infections (cUTI) including pyelonephritis caused by the following susceptible microorganisms: *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Citrobacter freundii* complex, *Proteus mirabilis*, and *Pseudomonas aeruginosa* **OR**
 - A diagnosis of Hospital-acquired Bacterial Pneumonia and Ventilator-associated Bacterial Pneumonia (HABP/VABP) caused by the following susceptible microorganisms: *Enterobacter cloacae*, *Escherichia coli*, *Haemophilus influenzae*, *Klebsiella pneumoniae*, *Proteus mirabilis*, *Pseudomonas aeruginosa* and, *Serratia marcescens*

AND

- Medical record documentation of culture and sensitivity showing the patient's infection is not susceptible to alternative antibiotic treatments **OR** a documented history of previous intolerance to or contraindication to other antibiotics shown to be susceptible on the culture and sensitivity

AUTHORIZATION DURATION: Approval will be given for a duration of 14 days.

LIMITATIONS: a quantity limit of 3 vials per day should apply, with total duration of treatment not exceeding 14 days.

LINE OF BUSINESS:

Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy.

This policy will be revised as necessary and reviewed no less than annually.

Devised: 7/21/15

Revised: 5/21/18 updated organisms per DHS, 7/17/18 (pneumonia), 7/16/19 (Age), 8/14/20 (per DHS age, crcl)

Reviewed: 5/27/16, 5/16/17, 5/1/18, 5/31/19, 7/1/20, 5/27/21