Policy: MBP 53.0
Section: Medical Benefit Pharmaceutical Policy
Subject: Eraxis (anidulafungin)

I. Policy:
Eraxis (anidulafungin)

II. Purpose/Objective:
To provide a policy of coverage regarding Eraxis (anidulafungin)

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

V. Additional Definitions
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:
Eraxis (anidulafungin) is an echinocandin antifungal agent that results in the inhibition of β-1,3-D-glucan synthase, an essential component of fungal cell walls.

CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee
Eraxis (anidulafungin) will be considered medically necessary when all of the following criteria are met:
- The insured individual is at least 17 years of age and non-neutropenic: AND
- There is physician provided documentation of a diagnosis of candidemia or other Candida infection as determined by an infectious disease specialist; OR
- There is physician provided documentation of a diagnosis of esophageal candidiasis with failure on, intolerance to, or contraindication to fluconazole therapy as determined by an infectious disease specialist.

AUTHORIZATION DURATION: Prior Authorization will be limited to a period of 6 weeks (one course of therapy). Re-authorization for an extended treatment period (beyond the initial 6 weeks) will require documentation of a continued positive culture or documentation of a positive culture within the previous 14 days of the request. Duration of treatment should be based on the patient’s clinical response. Therapy should continue for at least 14 days after the last positive culture. Requests for re-authorization will be limited to a duration of 2 weeks for each re-authorization request.

LIMITATIONS:
Specimens for fungal culture and other relevant laboratory studies (including histopathology) should be obtained prior to therapy to isolate causative organism(s). Therapy may be instituted before the results of cultures and other laboratory studies are known. However, once these results become available, antifungal therapy should be adjusted accordingly.

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: 4/27/07
Revised: 2/12 (PA timeframe), 1/20/15 (formatting changes), 9/12/18 (duration per DHS), 7/9/19 (per DHS)
Reviewed: 7/08; 11/09, 12/10, 2/14, 1/20/2015, 11/2/2015, 9/20/16, 7/31/17, 7/10/18, 5/31/19, 2/1/20