

Caspofungin (Candidas®)

Place of Service

Office Administration
Outpatient Facility
Administration*

[*Prior authorization required – see section (1)]

Infusion Center Administration
Home Infusion Administration
Hospital Administration

HCPCS: J3490

Condition(s) listed in policy (see criteria for details)

- [Antifungal prophylaxis in cancer patients](#)
- [Candida osteomyelitis or candida septic arthritis](#)
- [Chronic disseminated candidiasis \(hepatosplenic candidiasis\)](#)
- [Esophageal candidiasis](#)
- [Febrile neutropenia](#)
- [Intra-abdominal candidiasis](#)
- [Invasive Aspergillosis](#)
- [Invasive candidiasis/candidemia](#)
- [Oropharyngeal candidiasis](#)
- [Pulmonary aspergillosis](#)

AHFS therapeutic class: Antifungal agent; echinocandins

Mechanism of action: Semisynthetic, echinocandin antifungal agent

(1) Special Instructions and pertinent Information

Covered under the Medical Benefit, please submit clinical information for prior authorization review via fax.

****CRITERIA FOR HOSPITAL OUTPATIENT FACILITY ADMINISTRATION ****

AAAAI Guidelines 2011, MCG™ Care Guidelines, 19th edition, 2015

Members with the following plans: **PPO, Direct Contract HMO, and when applicable: ASO/Shared Advantage/HMO (non-direct contract)** may be required to have their medication administered at a preferred site of service, including the home, a physician's office, or an independent infusion center not associated with a hospital.

For members that cannot receive infusions in the preferred home or ambulatory setting AND meet one of the following criteria points, drug administration may be performed at a hospital outpatient facility infusion center.

ADMINISTRATION OF CANCIDAS IN THE HOSPITAL OUTPATIENT FACILITY SITE OF CARE REQUIRES ONE OF THE FOLLOWING: (Supporting Documentation must be submitted)

1. Patient is receiving their first infusion of Cancidas or is being re-initiated on Cancidas after at least 6 months off therapy. *Subsequent doses will require medical necessity for continued use in the hospital outpatient facility site of care.*

OR

Additional clinical monitoring is required during administration as evidenced by one of the following:

2. Patient has experienced a previous severe adverse event to Cancidas based on documentation submitted.
3. Patient continues to experience moderate to severe adverse events to Cancidas based on documentation submitted, despite receiving premedication such as acetaminophen, steroids, diphenhydramine, fluids, etc.
4. Patient is clinically unstable based on documentation submitted.
5. Patient is physically or cognitively unstable based on documentation submitted.

(2) Prior Authorization/Medical Review is required for the following condition(s)

All requests for Cancidas® (caspofungin) NOT listed in section 3 must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Antifungal prophylaxis in cancer patients

1. Being used as antifungal prophylaxis for cancer patients at high risk of febrile neutropenia [e.g. due to chemotherapy regimen, AML/MDS patient, undergoing HCST], **AND**
2. Inadequate response, intolerance, or contraindication to fluconazole, voriconazole or posaconazole

Covered Doses

Up to 70 mg IV on day one, followed by up to 50 mg IV daily

Coverage Period

2 months of therapy and reassess for continued efficacy

ICD-10: D70.1

Candida osteomyelitis or candida septic arthritis

1. Diagnosis only

Covered Doses

Up to 70 mg IV daily

Coverage Period

2 weeks

ICD-10:

B37.89

Chronic disseminated candidiasis (hepatosplenic candidiasis)

1. Diagnosis only

Covered Doses

Up to 70 mg IV on day one, followed by up to 50 mg IV daily

Coverage Period

2 months of therapy and reassess for continued efficacy

ICD-10:

B37.7

Esophageal candidiasis

1. Inadequate response, intolerance, or contraindication to fluconazole, OR proven culture resistant to fluconazole

Covered Doses

Up to 70 mg IV on day one, followed by up to 50 mg IV daily

Coverage Period

2 months of therapy and reassess for continued efficacy

ICD-10:

B37.81

Febrile neutropenia

1. Diagnosis only

Covered Doses

Up to 70 mg IV on day, followed by up to 50 mg IV daily

Coverage Period

2 months of therapy and reassess for continued efficacy

ICD-10:

D70.9

Intra-abdominal candidiasis

1. Diagnosis only (includes peritonitis and pleural space infections)

Covered Doses

Up to 70 mg IV on day one, followed by up to 50 mg IV daily

Coverage Period

Cover up to 2 months of therapy and reassess continued efficacy

ICD-10:

B37.9

Invasive Aspergillosis

1. Inadequate response, intolerance, or contraindication to an azole antifungal (i.e., itraconazole, voriconazole, posaconazole), or proven culture resistant to an azole antifungal

Covered Doses

Up to 70 mg IV on day one, followed by up to 50 mg IV daily

Coverage Period

2 months of therapy and reassess for continued efficacy.

ICD-10:

B44.0-B44.2, B44.7, B44.89, B44.9, B48.4

Invasive candidiasis/candidemia

1. Diagnosis only

Covered Doses

PHP Medi-Cal

Caspofungin (Cancidas®)

Up to 70 mg IV on day one, followed by up to 50 mg IV daily

Coverage Period

2 months of therapy and reassess for continued efficacy

ICD-10:

B37.7

Oropharyngeal candidiasis

1. Inadequate response, intolerance, or contraindication to an azole antifungal (ie: fluconazole, itraconazole, voriconazole, and posaconazole), OR proven culture resistant to an azole antifungal

Covered Doses

Up to 70 mg IV on day one, followed by up to 50 mg IV daily

Coverage Period

2 months of therapy and reassess for continued efficacy

ICD-10:

B37.0, B37.83

Pulmonary aspergillosis

1. Inadequate response, intolerance, or contraindication to itraconazole or voriconazole

Covered Doses

Up to 70 mg IV on day one, followed by up to 50 mg IV daily

Coverage Period

2 months of therapy and reassess for continued efficacy

ICD-10:

B44.0-B44.2, B44.7, B44.89, B44.9, B48.4

(3) The following condition(s) DO NOT require Prior Authorization/Preservice
All requests for Cancidas (caspofungin) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s)
Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How Supplied:

50 mg, 70 mg (lyophilized powder single-use vial)

(6) References

- AHFS®. Available by subscription at <http://www.lexi.com>
- Cancidas® (Caspofungin acetate) [Prescribing information]. Whitehouse Station, NJ: Merck & Co., Inc.; 8/2021.
- DrugDex®. Available by subscription at <http://www.micromedexsolutions.com/home/dispatch>
- Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Available at: https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/Adult_OI.pdf
- National comprehensive cancer network. Prevention and treatment of cancer-related infections (Version 1.2021). Available at: www.nccn.org/
- Pappas PG, Kauffman CA, Andes DR, et al. Clinical Practice Guideline for the treatment of Candidiasis: 2016 update by the Infectious Disease Society of America. Clin Infect Dis 2016; 62(4):e1-e50.
- Patterson TF, Thompson GR, Denning DW, et al: Practice guidelines for the diagnosis and management of aspergillosis: 2016 update by the Infectious Diseases Society of America. Clin Infect Dis 2016; 63(4): e1-e60.
- Taplitz RA, Kennedy EB, Bow EJ et al. Antimicrobial prophylaxis for adult patients with cancer-related immunosuppression: ASCO and IDSA clinical practice guideline update. J Clin Oncol 2018;36:3043-3054.

(7) Policy Update

Date of last review: 2Q2022

Date of next review: 2Q2023

Changes from previous policy version:

- No clinical change to policy following routine annual review.

*BSC Drug Coverage Criteria to Determine Medical Necessity
Reviewed by P&T Committee*