PRIOR AUTHORIZATION POLICY

POLICY: Antifungals (Azoles) – Intravenous Products Prior Authorization Policy
- Cresemba® (isavuconazonium sulfate intravenous infusion – Astellas)
- Fluconazole intravenous infusion – generic only
- Noxafil® (posaconazole intravenous infusion – Merck, generic)
- Vfend® (voriconazole intravenous infusion – Pfizer, generic)

REVIEW DATE: 3/6/2024

OVERVIEW

Cresemba intravenous infusion, fluconazole intravenous infusion, posaconazole intravenous infusion, and voriconazole intravenous infusion are azole antifungals. These products are indicated for prophylaxis and/or treatment of **systemic fungal infections**, including *Candida* infections, cryptococcal meningitis, esophageal candidiasis, invasive aspergillosis, and invasive mucormycosis.[1-4] The specific indications are different for the four products; refer to the prescribing information for details.

Injectable formulations of some antifungals have been compounded with other topical products (clindamycin, clotrimazole, ketoconazole, and mupirocin) to make foot baths and other products. There are no data to support these uses.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of the intravenous formulations of Cresemba, fluconazole, posaconazole, and voriconazole when these products are prescribed in conjunction with select topical products: clindamycin, clotrimazole, ketoconazole, and mupirocin. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days.

Automation: If there are no prescription claims for topical clindamycin, topical clotrimazole, topical ketoconazole, and/or topical mupirocin products in the past 180 days, the Prior Authorization edit will not be applied in adjudication. Prior Authorization will only apply to prescriptions for the intravenous formulations of Cresemba, fluconazole, posaconazole, and voriconazole when there is of topical clindamycin, topical clotrimazole, topical ketoconazole, and/or topical mupirocin products in the past 180 days.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Cresemba, fluconazole, posaconazole, and voriconazole is recommended in those who meet the following criteria:

FDA-Approved Indication

1. **Systemic Fungal Infections (Prophylaxis or Treatment).** Approve for 3 months.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Cresemba, fluconazole, posaconazole, and voriconazole is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Cresemba® capsule and intravenous infusion [prescribing information]. Northbrook, IL: Astellas; December 2023.
2. Fluconazole intravenous infusion [prescribing information]. Lake Forest, IL: Hospira; January 2023.
3. Noxafil® intravenous infusion, delayed-release tablets, oral suspension [prescribing information]. Whitehouse Station, NJ: Merck; September 2022.
4. Vfend® intravenous infusion [prescribing information]. New York, NY: Pfizer; October 2022.