**Infectious Disease Agents: Antifungals**

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| Criteria 1 | NP – Brexafemme, Cresemba, Itraconazole, Noxafil Susp, Oravig, Posaconazole, Tolsura, Voriconazole |
| Criteria 2 | NP- Vivjoa |

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| **Criteria Title** | Infectious Disease Agents: Antifungals | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| BREXAFEMME | 082353 | GCNSeqNo |
| CRESEMBA | 073654 | GCNSeqNo |
| ITRACONAZOLE | 016949 | GCNSeqNo |
| ITRACONAZOLE | 027465 | GCNSeqNo |
| NOXAFIL SUSP | 060365 | GCNSeqNo |
| ORAVIG | 063921 | GCNSeqNo |
| POSACONAZOLE | 071709 | GCNSeqNo |
| TOLSURA | 079357 | GCNSeqNo |
| VORICONAZOLE | 050442 | GCNSeqNo |
| VORICONAZOLE | 050443 | GCNSeqNo |
| VORICONAZOLE | 053774 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0996 |  | Select and Free Text | Does the patient have an infection that is caused by an organism resistant to **ALL** preferred antifungals?    If yes, please provide documentation of the diagnosis and any culture and sensitivity reports. | Y | END (Approve x 90 days) |
| N | 0997 |
| 2 | 0997 |  | Select | Is the patient completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility?  Please note: only the remaining course will be authorized. | Y | END (Approve x 90 days) |
| N | 0998 |
| 3 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 4 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 5 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 7 days with at least one preferred drug?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 6 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 7 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | END (Approve x 90 days) |
| 8 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Approve x 90 days) |
| N | 1235 |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment, ongoing safety monitoring, AND medical necessity for continued use? | Y | END (Approve x 90 days) |
| N | 1235 |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Based on indication

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| **Last Approved** | 4/24/2023 |
| **Other** |  |

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| **Criteria Title** | Infectious Disease Agents: Antifungals | | |
| **Criteria Subtitle** | Vivjoa | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| VIVJOA | 083329 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0996 |  | Select and Free Text | Does the patient have an infection that is caused by an organism resistant to **ALL** preferred antifungals?    If yes, please provide documentation of the diagnosis and any culture and sensitivity reports. | Y | END (Approve x 120 days) |
| N | 0997 |
| 2 | 0997 |  | Select | Is the patient completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility?  Please note: only the remaining course will be authorized. | Y | END (Approve x 120 days) |
| N | 0998 |
| 3 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 4 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 5 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 7 days with at least one preferred drug?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 6 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 7 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | 1004 |
| 8 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1004 |
| N | 1235 |
| 9 | 1004 |  | Select and Free Text | Has the provider submitted documentation that the patient has had at least three symptomatic episodes of vulvovaginal candidiasis in the past 12 months?  If yes, please submit documentation. | Y | 1005 |
| N | 1235 |
| 10 | 1005 |  | Select and Free Text | Has the provider submitted documentation that the patient is of non-reproductive potential (i.e., postmenopausal)?  If yes, please submit documentation. | Y | 1006 |
| N | 1235 |
| 11 | 1006 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 180 day maintenance course with oral fluconazole shown by documentation of more than one breakthrough infection?  If yes, please submit documentation. | Y | END (Approve x 120 days) |
| N | 1235 |
| 12 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment, ongoing safety monitoring, AND medical necessity for continued use? | Y | END (Approve x 120 days) |
| N | 1235 |
| 13 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 14 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Based on indication

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| --- | --- |
| **Last Approved** | 4/24/2023 |
| **Other** |  |