Topical Agents: Antifungals

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| Criteria 1 | NP Criteria - Butenafine, Ciclopirox Kit, Ertaczo, Ketoconazole Foam, Luliconazole, Miconazole/Zinc Oxide/White Petrolatum Oint, Naftifine, Oxiconazole, Tavaborole |
| Criteria 2 | NP Criteria - Jublia |

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| **Criteria Title** | Topical 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) |
| BUTENAFINE | 029333 | GCNSeqNo |
| CICLOPIROX KIT | 069465 | GCNSeqNo |
| CICLOPIROX KIT | 076273 | GCNSeqNo |
| CICLOPIROX KIT | 076938 | GCNSeqNo |
| CICLOPIROX KIT | 067434 | GCNSeqNo |
| ERTACZO | 030866 | GCNSeqNo |
| KETOCONAZOLE FOAM | 063088 | GCNSeqNo |
| LULICONAZOLE | 071700 | GCNSeqNo |
| MICONAZOLE/ZINC OXIDE/WHITE PETROLATUM OINT | 060413 | GCNSeqNo |
| NAFTIFINE | 007374 | GCNSeqNo |
| NAFTIFINE | 015525 | GCNSeqNo |
| NAFTIFINE | 068626 | GCNSeqNo |
| NAFTIFINE | 071236 | GCNSeqNo |
| OXICONAZOLE | 007375 | GCNSeqNo |
| OXICONAZOLE | 017183 | GCNSeqNo |
| TAVABOROLE | 072716 | 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 | Is the infection caused by an organism resistant to preferred antibiotics drugs? | Y | 0997 |
| N | 0998 |
| 2 | 0997 |  | Select and Free Text | Has the provider submitted documentation of that patient’s diagnosis and any culture/sensitivity results?  If yes, please submit supporting documentation. | Y | END (Approve x 180 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 14 days with at least two preferred drugs, if indicated for diagnosis?  The preferred alternatives may include the following: Alevazol, Ciclopirox, Clotrimazole, Clotrimazole/Betamethasone, Econazole, Ketoconazole, Miconazole, Nystatin, Nystatin/Triamcinolone, Terbinafine, Tolnaftate.  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 180 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 180 days) |
| N | 1235 |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 180 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: Up to 180 days

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| **Last Approved** | 5/1/2023 |
| **Other** |  |

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| **Criteria Title** | Topical Agents: Antifungals | | |
| **Criteria Subtitle** | Jublia | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| JUBLIA | 072429 | 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 | Is the infection caused by an organism resistant to preferred antibiotics drugs? | Y | 0997 |
| N | 0998 |
| 2 | 0997 |  | Select and Free Text | Has the provider submitted documentation of that patient’s diagnosis and any culture/sensitivity results?  If yes, please submit supporting documentation. | Y | END (Pending Manual Review) |
| 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 365 days with at least one preferred topical drug?  If yes, please submit the medication trials and dates. | Y | 1001 |
| N | 1003 |
| 6 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 84 days with at least one preferred oral drug indicated for diagnosis?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1003 |
| 7 | 1002 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least two preferred drugs, if indicated for diagnosis?  If yes, please submit the medication trials and dates. | Y | 1004 |
| N | 1003 |
| 8 | 1003 |  | 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 | 1004 |
| N | 1236 |
| 9 | 1004 |  | 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 | 1005 |
| N | END (Pending Manual Review) |
| 10 | 1005 |  | 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 (Pending Manual Review) |
| N | 1235 |
| 11 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 12 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 13 | 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: 365 days

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| **Last Approved** | 5/1/2023 |
| **Other** |  |