Pharmacy Medical Necessity Guidelines: Oral Antifungal Agents

Effective: May 12, 2020

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☐ Tufts Health Plan Commercial products – large group plans
☐ Tufts Health Plan Commercial products – small group and individual plans
☐ Tufts Health Freedom Plan products – large group plans
☐ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM: 617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Flucytosine:

- Flucytosine is indicated only in the treatment of serious infections caused by susceptible strains of *Candida* and/or *Cryptococcus.*
- *Candida*: Septicemia, endocarditis and urinary system infections have been effectively treated with flucytosine. Limited trials in pulmonary infections justify the use of flucytosine.
- *Cryptococcus*: Meningitis and pulmonary infections have been treated effectively. Studies in septicemias and urinary tract infections are limited, but good responses have been reported.
- Flucytosine should be used in combination with amphotericin B for the treatment of systemic candidiasis and cryptococcosis because of the emergence of resistance.

Posaconazole:

- Posaconazole oral suspension is indicated for the treatment of oropharyngeal candidiasis, including oropharyngeal candidiasis refractory to itraconazole and/or fluconazole in patients at least 13 years of age.
- Posaconazole oral suspension and delayed-release tablets are indicated as prophylaxis of invasive *Aspergillus* and *Candida* infections in patients at least 13 years who are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant recipients with graft-vs-host disease or those with hematologic malignancies with prolonged neutropenia from chemotherapy.

Voriconazole:

- Voriconazole is indicated for use in patients at least 2 years for the treatment of invasive aspergillosis; candidemia (nonneutropenic) and disseminated candidiasis in skin, abdomen, kidney, bladder wall, and wounds; esophageal candidiasis; and serious infections caused by *Scedosporium apiosperman* and *Fusarium* species including *Fusarium solani*, in patients intolerant of, or refractory to, other therapy.

COVERAGE GUIDELINES

The plan may authorize coverage of an oral antifungal agent for Members when **all** of the following criteria for a particular regimen are met:

Flucytosine

1. Documented diagnosis of cryptococcal meningitis

OR

2. Documented diagnosis of candida endocarditis

OR

3. Documented diagnosis of a cryptococcal pulmonary infection AND documentation of clinical inappropriateness of treatment with at least one first-line agent (e.g., fluconazole, itraconazole, or voriconazole)

OR

4. Documented diagnosis of candida septicemia AND documentation of clinical inappropriateness of treatment with first-line agents (e.g., fluconazole, voriconazole, amphotericin B, or an echinocandin)

OR

5. Documented diagnosis of candiduria AND documentation of clinical inappropriateness of treatment with fluconazole AND amphotericin B monotherapy

Posaconazole

The member is 13 years of age or older **AND** meets one of the following:

1. Documented diagnosis of Zygomycosis (mucormycosis)

OR

2. Documented diagnosis of prevention of invasive aspergillus and candida fungal infections AND documentation of hematologic malignancy with neutropenia, hematopoietic stem cell transplant, or graft-versus-host disease

OR

3. Documented diagnosis of esophageal candidiasis AND the request is for the oral suspension AND documented failure of or clinical inappropriateness of therapy with at least TWO of the following: oral fluconazole, itraconazole, and voriconazole

OR

4. Documented diagnosis of oropharyngeal candidiasis AND the request is for the oral suspension AND documented failure of or clinical inappropriateness of therapy with all of the following: oral fluconazole and itraconazole

Voriconazole

The Member is 2 years of age or older **AND** meets one of the following:

1. Documented diagnosis of an invasive aspergillus infection

OR

2. Documented diagnosis of a serious infection case by scedosporium and fusarium species

OR

3. Documented diagnosis of esophageal candidiasis AND documented failure of or clinical inappropriateness to fluconazole and itraconazole

OR

4. Documented diagnosis of oropharyngeal candidiasis AND documented failure of or clinical inappropriateness of treatment with all of the following: fluconazole, itraconazole, posaconazole

OR

5. Documented diagnosis of candidemia and disseminated candidiasis infections AND documented failure of or clinical inappropriateness to oral fluconazole

OR

6. Documented diagnosis of prevention of invasive aspergillus and candida fungal infections AND documentation of hematologic malignancy with neutropenia, hematopoietic stem cell transplant, or graft-versus-host disease

LIMITATIONS

1. Approval will be limited to one complete course of therapy.
2. Requests for brand-name products, which have AB-rate generics, will be reviewed according to Brand Name criteria.
3. The following quantity limits apply to coverage:

Voriconazole oral tablet	180 tablets per 30 days

CODES

None

REFERENCES

1. Ancobon (flucytosine) [package insert]. Bridgewater, NJ: Valent Pharmaceuticals International; February 2019.
2. Noxafil (posaconazole) [prescribing information]. Whitehouse Station, NJ: Merck & Co Inc; March 2019.

3. Vfend (voriconazole) [prescribing information]. New York, NY: Pfizer; January 2019.
4. Perfect JR, Dismukes WE, Dromer F, et al. Clinical practice guidelines for the management of cryptococcal disease: 2010 update by the Infectious Diseases Society of America. *Clin Infect Dis*. 2010;50(3):291-322.

APPROVAL HISTORY

January 13, 2015: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
1. January 1, 2016: Administrative change to rebranded template.
2. March 8, 2016: No changes
3. March 14, 2017: Removed terbinafine oral granules from the criteria due to product discontinuation. Specified voriconazole quantity limit.
4. May 9, 2017: Administrative update, Adding Tufts Health RITogether to the template.
5. May 8, 2018: No changes.
6. June 11, 2019: Decreased the approvable age of voriconazole from 12 years of age to 2 years of age. Administrative changes made to template. Updated the criteria for voriconazole to include the diagnosis of oropharyngeal candidiasis. Updated the criteria for posaconazole for the diagnosis of oropharyngeal candidiasis to require trial and failure with itraconazole and fluconazole.
7. May 12, 2020: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.