Anti-Fungal agents
(Separate criteria for Vfend- Voriconazole)

1. Does member have a funded condition if OHP criteria are met?
   (Minor fungal infections of the skin are funded as opportunistic infections if member is immunocompromised OR is on continuous antibiotic therapy- See below)
   a. Yes – Continue to question
   b. No – Deny Cat 1/Cat 5 – *Condition not funded on OHP prioritized list- member is not immunocompromised or on continuous antibiotic therapy*

Immunocompromising conditions	Immunosuppressive Drugs	
-Current (not history of) diagnosis of cancer and undergoing chemo or radiation therapy. -HIV/ AIDs -Sickle Cell anemia -Other conditions as determined by pharmacist (poor nutrition, elderly, chronic illness)	Abatacept (Orencia) Adalimumab (Humira) Azathioprine (Imuran) Basilximab (Simulect) Certolizumab (Cimzia) Cyclophosphamide (Cellcept) Cyclosporine Etanercept (Enbrel) Everolimus (Zortress) Golimumab (Simponi Hydroxychloroquine Inflixiamab biosimlar (Inflectra, Renflexis)	Infliximab (Remicade) Ixekizumab (Talz) Leflunomide (Arava) Mercaptopurine Methotrexate Mycophenolate Rituximab (Rituxan) Secukinumab (Cosentyx) Sirolimus (Rapamune Tacrolimus (Prograf) Tocilizumab (Actemra) Tofacitinib (Xeljanz) Ustekinumab (Stelara)

2. Is the request for a formulary agent *other than voriconazole*?
   a. Yes – Continue to question 4
   b. No- Continue to question 3

3. Has the member tried and failed formulary option OR are formulary options not appropriate?
   a. Yes – Continue to question 4
   b. No – Deny Cat 15 – *Member has not exhausted formulary options of treatment.*

4. Is the medication appropriate for prescribed indication?
   - Clotrimazole troches- Prophylaxis and treatment of oropharyngeal candidiasis
   - Fluconazole - Candidiasis and Cryptococcus
   - Griseofulvin- Dermatophyte infections
   - Isavuconazole- Invasive Aspergillosis and mucormycosis in patients failing voriconazole
   - Itraconconazole – Aspergillosis, blastomycosis, candidiasis, coccidioidmycosis, histoplasmosis, sporotrichosis- **Must have t/f prior treatment with fluconazole if appropriate**
   - Ketoconazole- Treatment of susceptible systemic fungal infections, including blastomycosis, histoplasmosis, coccidioidomycosis, and chromomycosis in patients who have failed or who are intolerant to other antifungal therapies
     * Ketoconazole should only be used when other effective antifungal therapy is not available or tolerated and the potential benefits outweigh the potential risks*

- Nystatin tablets- Intestinal infections *list continued*
- Posaconazole- Invasive aspergillosis or disseminated candidiasis in immunocompromised patient.
- Terbinafine- onychomycosis (not funded), Tinea capitis (not funded)

a. Yes- May approved for up to 3 months
b. No- Deny Cat 3- *Medication is being prescribed outside of FDA approved indications*

Vfend (Voriconazole)

1. Does member have a funded condition?
    a. Yes, Continue to question 2
    b. No, Deny Cat 1- *Member does not have a funded condition on the OHP prioritized list*

2. Does member have one of the following while <u>under treatment from ID specialist or hematologist/oncologist?</u>
    - Invasive Aspergillus
    - Fungal infection due to Scedosporium apiospermum or Fusarium specie
    - A high risk of developing invasive Aspergillus or Candida due to being severely immunocompromised, such as an allogeneic hematopoietic stem cell transplant [HSCT] recipient; a patient with a hematologic malignancy (leukemia, lymphoma, myelodysplastic syndrome) with prolonged neutropenia from chemotherapy; or a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient

    a. Yes, Approve for 6 months
    b. No, Continue to question 3

3. Does the member have one of the following:
    - esophageal candidiasis
    - Candidiasis in non-neutropenic patient

    a. Yes, Continue to question 4
    b. No, - Deny cat 3- *Medication is being prescribed outside of FDA approved indications*

4. Has the member tried and failed or have contraindication to fluconazole or alternative antifungal agent?
    a. Yes, Approve for up to 3 months
    b. No, Deny Cat 5- *Member has not had trial of or shown intolerance to preferred treatment alternatives.*