# GEORGIA MEDICAID FEE-FOR-SERVICE ANTIFUNGALS, ORAL PA SUMMARY

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
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<tbody>
<tr>
<td>Clotrimazole oral troche generic</td>
<td>Cresemba capsules (isavuconazonium)</td>
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<td>Fluconazole tablets, oral suspension generic</td>
<td>Flucytosine capsules generic</td>
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<td>Itraconazole capsules generic*</td>
<td>Griseofulvin tablets, oral suspension generic</td>
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<td>Ketoconazole tablets generic</td>
<td>Lamisil Granules (terbinafine)</td>
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<td>Nystatin tablets, oral suspension generic</td>
<td>Noxafil (posaconazole tablets, oral suspension)</td>
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<tr>
<td>Sporanox oral solution (itraconazole)*</td>
<td>Oravig (miconazole buccal tablets)</td>
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<td>Terbinafine tablets generic</td>
<td>Voriconazole oral suspension, tablets generic</td>
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*preferred but requires PA

**LENGTH OF AUTHORIZATION:** Varies

**NOTES:**

- Itraconazole capsules and Sporanox oral solution are preferred but require prior authorization (PA).
- If generic voriconazole suspension is approved, the PA will be issued for brand Vfend suspension.

**PA CRITERIA:**

**Itraconazole Capsules**

- Approvable for members with a diagnosis of onychomycosis who have a positive KOH preparation, fungal culture or nail biopsy and have experienced ineffectiveness, allergy, drug-drug interaction, contraindication or intolerable side effect with oral terbinafine.
- Approvable for members with a diagnosis of aspergillosis, blastomycosis or histoplasmosis.
- Approvable for members with a diagnosis of tinea versicolor, tinea cruris, tinea corporis or tinea pedis when infection involves a large area of the body, member is immunocompromised, or member has ineffectiveness with at least one OTC or prescription topical antifungal agent.

**Sporanox Oral Solution**

- Approvable for members with a diagnosis of oropharyngeal candidiasis (thrust), esophageal candidiasis or empiric febrile neutropenia.
- Approvable for members unable to swallow capsules who meet the following criteria:
  - Members with a diagnosis of onychomycosis who have a positive KOH preparation, fungal culture or nail biopsy and have experienced ineffectiveness, allergy, drug-drug interaction, contraindication or intolerable side effect with oral terbinafine (Lamisil).
  - Members with a diagnosis of aspergillosis, blastomycosis or histoplasmosis.
Members with a diagnosis of tinea versicolor, tinea cruris, tinea corporis or tinea pedis when infection involves a large area of the body, member is immunocompromised, or member has experienced ineffectiveness with at least one OTC or prescription topical antifungal agent.

**Cresemba Capsules**
- Approvable for members as a continuation of therapy after being started on therapy in the hospital.
- Approvable for members 18 years of age or older with a diagnosis of invasive aspergillosis who have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effect with voriconazole.
- Approvable for member 18 years of age or older with a diagnosis of invasive mucormycosis/zygomycosis.

**Flucytosine Capsules Generic**
- Approvable for members as a continuation of therapy after being started on therapy in the hospital.
- Approvable for members with a diagnosis of Candida infection of cardiovascular system, CNS (meningitis) or eye (endophthalmitis).
- Approvable for members with a diagnosis of cryptococcosis.
- Approvable for members with a diagnosis of Candida urinary tract infection (cystitis, pyelonephritis, candiduria) who have experienced ineffectiveness, resistance, allergy, contraindication, drug-drug interaction or intolerable side effect with fluconazole.

**Griseofulvin Generic**
- Approvable for members 2 to 11 years of age with a diagnosis of tinea capitis.
- Approvable for members 12 years of age or older with a diagnosis of tinea capitis who have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effect with oral terbinafine.
- Approvable for members with a diagnosis of onychomycosis (tinea pedis or tinea unguium) or other tinea infection who have experienced ineffectiveness, allergies, contraindications, drug-drug interactions or intolerable side effects with oral terbinafine and itraconazole.

**Lamisil Oral Granules**
- Approvable for members 4-12 years of age with a diagnosis of tinea capitis.

**Noxafil**
- Approvable for members requiring preventative therapy for invasive aspergillosis or candidiasis in severely immunocompromised members.
- Approvable for members with a diagnosis of invasive aspergillosis, mucormycosis/zygomycosis, fusariosis or other molds that are resistant to previous systemic antifungal therapy.
- Approvable for members with a diagnosis of oropharyngeal candidiasis who have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effects with itraconazole or fluconazole.
Onmel

❖ For members with a diagnosis of onychomycosis, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic itraconazole capsules, is not appropriate for the member.

Oravig

❖ Approvable for members as a continuation of therapy after being started on therapy in the hospital.
❖ Approvable for members 16 years of age or older with a diagnosis of oropharyngeal candidiasis who have experienced ineffectiveness, allergies, contraindications, drug-drug interactions or intolerable side effects with two of the following: clotrimazole troches, nystatin oral suspension and fluconazole.

Vfend Suspension and Voriconazole Suspension, Tablets Generic

❖ Approvable for members as a continuation of therapy after being started on therapy in the hospital.
❖ Approvable for members who have tried one other systemic antifungal agent and who have one of the following diagnoses:
  o Esophageal candidiasis
  o Candidemia in nonneutropenic patient
  o Disseminated Candida skin infection
  o Candida infection in abdomen, kidney, bladder wall or wound
❖ Approvable for members with invasive or pulmonary aspergillosis, fungal infection caused by Scedosporium apiospermum, or fungal infection caused by Fusarium species.
❖ Approvable for prophylaxis of aspergillosis, candidiasis or invasive fungal infection in severely immunocompromised patients.
❖ Approvable for central nervous system (CNS) blastomycosis who have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effect with itraconazole.

QLL CRITERIA:

Itraconazole Capsules and Sporanox Oral Solution

❖ An authorization to exceed the QLL may be granted for members with aspergillosis, blastomycosis or histoplasmosis.

EXCEPTIONS:

• Exceptions to these conditions of coverage are considered through the prior authorization process.
• The Prior Authorization process may be initiated by calling OptumRx at 1-866-525-5827.

PREFERRED DRUG LIST:

• For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.
PA and APPEAL PROCESS:

- For online access to the PA process, please go to [www.dch.georgia.gov/prior-authorization-process-and-criteria](http://www.dch.georgia.gov/prior-authorization-process-and-criteria) and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL List.