**GEORGIA MEDICAID FEE-FOR-SERVICE**  
**ANTIFUNGALS PA SUMMARY**

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<td>Fluconazole tablets, oral suspension generic</td>
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<td>Flucytosine generic</td>
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<td>Noxfil (posaconazole)</td>
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<td>Nystatin tablets, oral suspension generic</td>
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<td>Sporanox oral solution (itraconazole)*</td>
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| **Injection** |               |
| Abeli (amphotericin B lipid complex) | Ambisome (amphotericin B liposome) |
| Amphotericin B generic | Cancidas (caspofungin) |
| Fluconazole injection generic* | Voriconazole injection generic |

| **Topical** |               |
| Ciclopirox 8% nail lacquer (solution)* | Ciclodan Kit (ciclopirox 8% solution) |
| Ciclopirox cream, suspension generic | Ciclodan Cream Kit (ciclopirox cream 0.77%, cleanser) |
| Econazole cream generic | CNL8 Nail Kit (ciclopirox 8% solution: 6-month supply and includes three 5mL bottles, 25 SwabPlus nail lacquer remover swabs and 1 emery board) |
| Ketoconazole cream, shampoo generic | Ciclopirox gel, shampoo generic |
| Miconazole generic | Ertaczo (sertaconazole) |
| Nystatin cream, ointment, powder generic | Exelderm (sulconazole) |
|                       | Extina foam (ketoconazole 2%) |
|                       | Jublia (efinaconazole) |
|                       | Kerydin (tavaborole) |
|                       | Ketoconazole 2% foam |
|                       | Loprox Kit (ciclopirox suspension, cleanser) |
|                       | Luzu (luliconazole) |
|                       | Mentax (butenafine) |
|                       | Naftifine cream generic |
|                       | Nystatin/triamcinolone cream and ointment generic |
|                       | Oxistat (oxiconazole) |
|                       | Pediaderm AF Kit (nystatin cream and diaper rash cream) |
|                       | Vusion (miconazole/petrolatum/zinc oxide) |

*preferred but requires PA

**LENGTH OF AUTHORIZATION:** Varies

**NOTES:**
- Itraconazole capsules, Sporanox oral solution, fluconazole injection and ciclopirox nail lacquer are preferred but require PA.
- Ertaczo, Exelderm, Mentax and Oxistat are non-preferred but do not require PA.
- Pediaderm AF Kit is only covered for members less than 21 years of age.

Revised 7/1/2017
If generic ketoconazole foam is approved, the PA will be issued for brand Extina. If generic voriconazole suspension is approved, the PA will be issued for brand Vfend suspension.

If injectable medication is being administered in a physician’s office then the medication must be billed through the DCH physician’s injectable program and not the outpatient pharmacy program. Information regarding the physician’s injectable program is located at www.mmis.georgia.gov.

**PA CRITERIA:**

**Oral**

*Impavido*

- Approvable for members who have been started on the medication as continuation of therapy
- Approvable for members 12 years of age or older who weigh 30 kg or more with a diagnosis of visceral leishmaniasis (VL) due to *Leishmania donovani* who have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effect with amphotericin B liposome (Ambisome), or the member is not a candidate for intravenous (IV) therapy
- Approvable for members 12 years of age or older who weigh 30 kg or more with a diagnosis of cutaneous leishmaniasis (CL) due to *Leishmania braziliensis*, *Leishmania guyanensis* or *Leishmania panamensis*
- Approvable for members 12 years of age or older who weigh 30 kg or more with a diagnosis of mucosal leishmaniasis (ML) due to *Leishmania braziliensis*

**AND**

- Female members of reproductive potential must be informed of the risk of embryo-fetal toxicities and use effective contraception (if applicable) prior to the first dose, during treatment and for at least 5 months after receiving the last dose of medication.

*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 (Lamisil).
- 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 (thrush), 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 (Vfend).
- Approvable for member 18 years of age or older with a diagnosis of invasive mucormycosis/zygomycosis who have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effect with posaconazole (Noxafil).

Griseofulvin Microsize Generic

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, griseofulvin ultramicrosize, is not appropriate for the member.

Lamisil Oral Granules

- Approvable for members 4-12 years of age with a diagnosis of tinea capitis who have experienced ineffectiveness, allergy, drug-drug interaction, contraindication or intolerable side effect to griseofulvin.

Noxafil

- Approvable for members as a continuation of therapy after being started on therapy in the hospital for approvable diagnoses below.
- 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 (Sporanox) or fluconazole (Diflucan).

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.

Revised 7/1/2017
**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, Injection 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:
  - Oropharyngeal candidiasis
  - Candidemia in nonneutropenic patient
  - Disseminated Candida skin infection
  - 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 to itraconazole (Sporanox).
- Voriconazole injection must be administered in a member’s home by home health or in a long-term care facility and must require intravenous therapy.

**Injection (except voriconazole injection above)**

**Fluconazole Injection Generic**

- Medication must be administered in member’s home by home health or in a long-term care facility.

**Ambisome**

- Approvable for members who have been started on the medication as continuation of therapy.
- Approvable for members with a diagnosis of visceral leishmaniasis (VL).
- For members with other diagnosis, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Abelcet, is not appropriate for the member.

**Cancidas**

- Approvable for members who have been started on the medication as continuation of therapy.
- Approvable for members who have experienced ineffectiveness, allergy, contraindications drug-drug interaction or intolerable side effect with amphotericin B (Abelcet, Ambisome, Fungizone) or fluconazole (Diflucan).
Topical

_Ciclopirox 8% Generic, CNL8, Ciclodan Kit_

- Approvable for members with mild to moderate onychomycosis or white superficial onychomycosis who have diabetes mellitus, peripheral vascular disease or immunocompromised status and have a positive fungal culture result for Trichophyton rubrum or Trichophyton mentagrophytes.
- Approvable for members with moderate to severe onychomycosis who have diabetes mellitus, peripheral vascular disease or immunocompromised status, have a positive fungal culture result for Trichophyton rubrum or Trichophyton mentagrophytes and have experienced ineffectiveness, allergy, drug-drug interaction, contraindication or intolerable side effect with oral terbinafine (Lamisil).

_Ciclodon Cream Kit_

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic ciclopirox cream, is not appropriate for the member.

_Ciclopirox Gel Generic_

- Approvable for members with a diagnosis of seborrheic dermatitis who have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effect with generic ketoconazole shampoo.
- For members with a diagnosis of tinea corporis, tinea cruris, tinea pedis or cutaneous candidiasis, prescriber must submit a written letter of medical necessity stating the reasons the preferred products, generic ciclopirox cream and suspension, are not appropriate for the member.

_Ciclopirox Shampoo Generic_

- Approvable for members with a diagnosis of seborrheic dermatitis who have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effect with generic ketoconazole shampoo.

_Extina, Ketoconazole Foam Generic_

- For members 12 years of age or older with a diagnosis of seborrheic dermatitis, prescriber must submit a written letter of medical necessity stating the reasons the preferred products, generic ketoconazole cream and shampoo, are not appropriate for the member.

_Jublia, Kerydin_

- Approvable for members with a diagnosis of onychomycosis who have diabetes mellitus, peripheral vascular disease or immunocompromised status, have a positive fungal culture result for Trichophyton rubrum or Trichophyton mentagrophytes and have experienced ineffectiveness, allergies, drug-drug interactions, contraindications or intolerable side effects with oral terbinafine (Lamisil) and ciclopirox 8% solution (Penlac).

_Loprox Kit_

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic ciclopirox suspension, is not appropriate for the member.
Luzu
- Approvable for members age 18 or older with a diagnosis of tinea corporis, tinea cruris or tinea pedis confirmed by KOH (potassium hydroxide preparation) or cell culture test who have experienced ineffectiveness with at least one OTC or prescription topical antifungal agent.

Naftifine Generic
- Approvable for members who have experienced ineffectiveness with at least one OTC or prescription topical antifungal agent.

Nystatin/Triamcinolone Cream and Ointment Generic
- Prescriber must submit a written letter of medical necessity stating the reasons the separate preferred products, generic nystatin cream or ointment and generic triamcinolone cream or ointment, are not appropriate for the member.

Pediaderm AF Kit
- Prescriber must submit a written letter of medical necessity stating the reasons the two separate products, generic nystatin cream and OTC diaper rash cream, are not appropriate for the member.

Vusion
- Approvable for members 4 weeks of age or older with a diagnosis of diaper dermatitis when the presence of a candidal infection has been confirmed by a microscopic evaluation and member has experienced ineffectiveness with at least one OTC or prescription topical antifungal agent within the past 60 days.

QLL CRITERIA FOR SPORANOX (ITRACONAZOLE) CAPSULES OR PULSEPACK (QLL IS SET AT 60/30 DAYS):
- 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 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, highlight Provider Information and click on

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Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.