



TOPICAL ANTIFUNGALS PA SUMMARY

PREFERRED	Ciclopirox (cream, suspension), Ketoconazole (cream, shampoo), Loprox gel, Miconazole
NON-PREFERRED	Ciclodan Kit, Ciclopirox (gel, shampoo), Econazole cream, Ertaczo (PA not required), Exelderm (PA not required), Extina foam (ketoconazole 2%), Ketoconazole 2% foam, Ketodan Kit, Loprox cream/suspension (PA not required), Loprox shampoo, Lotrisone lotion (PA not required), Mentax (PA not required), Naftin, Oxistat (PA not required), Vusion

LENGTH OF AUTHORIZATION: Varies

NOTE: If Ketoconazole foam is approved, the PA will be issued for the brand-name product, Extina. If ciclopirox shampoo is approved, the PA will be issued for the brand-name product, Loprox shampoo. PA criteria for ciclopirox solution (Ciclodan, CNL8, Penlac) is located in the "Oral Antifungals and Ciclopirox Soln" document.

PA CRITERIA:

For Ciclodan Kit

- ❖ Submit a written letter of medical necessity stating the reason(s) that generic ciclopirox cream 0.77% (preferred medication) is not appropriate for the member.

For Ciclopirox Gel

- ❖ Submit a written letter of medical necessity stating the reason(s) that brand-name Loprox gel 0.77% (preferred medication) is not appropriate for the member.

For Loprox (Ciclopirox) Shampoo

- ❖ Approvable for the diagnosis of seborrheic dermatitis
- AND*
- ❖ Member must have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to generic ketoconazole shampoo.

For Ketoconazole Foam or Ketodan Kit

- ❖ Approvable for members age 12 or older with a diagnosis of seborrheic dermatitis
- AND*
- ❖ Provider should submit a written letter of medical necessity stating the reason(s) the preferred product, generic ketoconazole cream or shampoo, is not appropriate for the member.



For Econazole or Naftin

- ❖ Member must have experienced trial and failure of at least one OTC or prescription topical antifungal agent that does not require prior authorization.

For Vusion

- ❖ Approvable for members age 4 weeks or older with a diagnosis of diaper dermatitis when the presence of a candidal infection has been confirmed by a microscopic evaluation

AND

- ❖ Member must have experienced trial and failure of a topical antifungal agent (OTC or prescription) within the past 60 days.

EXCEPTIONS:

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

PA and APPEAL PROCESS:

- ❖ For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on “prior approval process”.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limit please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.