

## Antifungals

### Goal(s):

- Approve use of antifungals only for OHP-funded diagnoses. Minor fungal infections of skin, such as dermatophytosis and candidiasis are only funded when complicated by an immunocompromised host.
- Allow case-by-case review for members covered under the EPSDT program.

### Length of Authorization:

- See criteria

### Requires PA:

- Non-preferred drugs

### Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at
- Searchable site for Oregon FFS Drug Class listed at [www.orpd.org/drugs/](http://www.orpd.org/drugs/)

**Table 1: Examples of FUNDED indications (10/19/23)**

ICD-10	Description
B37.3	Candidiasis of vulva and vagina (vaginitis and cervicitis)
B37.1	Candidiasis of the lung
B37.7	Disseminated Candidiasis
B37.5-37.6, B37.81-37.84, B37.89-37.90	Candidiasis of other specified sites
B38.0-B38.4, B38.7, B38.9	Coccidiomycosis various sites
B39.0-39.5, B39.9, G02, I32, I39, J17	Histoplasmosis, subacute meningitis, acute bacterial meningitis
B40.9, B41.0, B41.9, B48.0	Blastomycosis
B42.0-42.9, B43.9, B44.9-45.0, B45.7, B45.9, B46.9, B48.1-48.2, B49	Rhinosporidiosis, Sporotrichosis, Chromoblastomycosis, Aspergillosis, Mycosis Mycetomas, Cryptococcosis, Allescheriosis, Zygomycosis, Dematiaceous Fungal Infection, Mycoses Nec and Nos
B48.8	Mycosis, Opportunistic
B44.81	Bronchopulmonary Aspergillus, Allergic
N73.9-75.1, N76.0-N77.1	Acute inflammatory pelvic disease
L03.019, L03.029, L03.039, L03.049	Cellulitis and abscess of finger and toe
P37.5	Neonatal Candida infection
B37.42, B37.49	Candidiasis of other urogenital sites
L30.4	Severe intertrigo (see HERC guideline note 21 for definition of severe inflammatory skin disease)

**Table 2: Examples of NON-FUNDED indications (12/16/21)**

ICD-10	Description
L2.083, L2.10-2.11, L21.8-21.9,	Erythemasquamous dermatosis
L22	Diaper or napkin rash
L20.0-20.84, L20.89-20.9	Other atopic dermatitis and related conditions
L24.0-24.2, L25.1-25.5, L57.8, L57.9,	Contact dermatitis and other eczema

L23.0, L23.81, L24.81, L25.0, L25.2, L25.8-25.9, L55.1-55.2, L56.8, L58.9	
L53.0-53.2, L51.0, L51.8-51.9, L52, L71.0-71.1, L71.8, L93.0, L93.2, L49.0-L49.9, L26, L30.4, L53.8, L92.0, L95.1, L98.2, L53.9	Erythematous conditions
L43.8, L44.1-44.3, L44.9, L66.1	Lichen Planus
L70.0-70.2, L70.8	Rosacea or acne
B36.0	Pityriasis versicolor
B36.2	Tinea blanca
B36.3	Black piedra
B36.8, B36.9	Mycoses, superficial
B37.2	Cutaneous candidiasis
B37.9	Candidiasis, unspecified
R21	Rash and other nonspecific skin eruption

**Table 3: Criteria driven diagnoses (1/1/24)**

ICD-10	Description
B35.0	Dermatophytosis of scalp and beard (tinea capitis/ tinea barbae)
B35.1	Tinea unguium (onychomycosis)
B35.2	Dermatophytosis of hand (tinea manuum)
B35.6	Dermatophytosis of groin and perianal area (tinea cruris)
B35.3	Dermatophytosis of foot (tinea pedis)
B35.5	Dermatophytosis of body (tinea corporis / tinea imbricate)
B35.8	Deep seated dermatophytosis
B35.8-B35.9	Dermatophytosis of other specified sites - unspecified site
B36.1	Tinea nigra
B37.83	Candidiasis of mouth

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code	
2. Is the diagnosis funded by OHP? (See examples in Table 1).	<b>Yes:</b> Go to #3	<b>No:</b> Go to #8
3. Is the request for oteseconazole?	<b>Yes:</b> Go to #4	<b>No:</b> Go to #7
4. Does the patient have a diagnosis of recurrent vulvovaginal candidiasis (RVVC) defined as a history of 3 or more episodes of acute vulvovaginal candidiasis (VCC) in the previous 12 months?	<b>Yes:</b> Go to #5	<b>No:</b> Pass to RPh. Deny; medical appropriateness.
5. Has the patient failed to have benefit with, or have contraindications or intolerance to, a course of oral fluconazole for recurrent vulvovaginal candidiasis?	<b>Yes:</b> Go to #6	<b>No:</b> Pass to RPh. Deny; medical appropriateness.

Approval Criteria		
6. Is the patient of reproductive potential?	<b>Yes:</b> Pass to RPh. Deny; medical appropriateness.	<b>No:</b> Approve up to 18 capsules for 12 months
7. Will the prescriber consider a change to a preferred product? Message: <ul style="list-style-type: none"> <li>Preferred products do not require PA.</li> <li>Preferred products are evidence-based reviewed for comparative effectiveness and safety.</li> </ul>	<b>Yes:</b> Inform prescriber of preferred alternatives.	<b>No:</b> Approve for 3 months or course of treatment.
8. Is the prescriber a hematology, oncology or infectious disease specialty prescriber requesting voriconazole or posaconazole?	<b>Yes:</b> Approve for 3 months or course of treatment.	<b>No:</b> Go to #9
9. Is the diagnosis not funded by OHP? (see examples in Table 2).	<b>Yes:</b> Current age $\geq$ 21 years: Pass to RPh. Deny; not funded by OHP  Current age < 21 years: Go to #10	<b>No:</b> Go to #10
10. Is the diagnosis funded by OHP if criteria are met? (see examples in Table 3).	<b>Yes:</b> Go to #11	<b>No:</b> Current age $\geq$ 21 years: Go to #16  Current age < 21 years: Go to #16
11. Is the patient immunocompromised (examples below)? <ul style="list-style-type: none"> <li>Does the patient have a current (not history of) diagnosis of cancer <b>AND</b> is currently undergoing Chemotherapy or Radiation? Document therapy and length of treatment. <b>OR</b></li> <li>Does the patient have a diagnosis of HIV/AIDS? <b>OR</b></li> <li>Does the patient have sickle cell anemia?</li> <li>Poor nutrition, elderly or chronically ill?</li> <li>Other conditions as determined and documented by a RPh.</li> </ul>	<b>Yes:</b> Record ICD-10 code. Approve as follows: (immunocompromised patient)  <b>ORAL &amp; TOPICAL</b> <ul style="list-style-type: none"> <li>Course of treatment.</li> <li>If length of therapy is unknown, approve for 3 months.</li> </ul>	<b>No:</b> Go to #12

## Approval Criteria

12. Is the patient currently taking an immunosuppressive drug? Document drug.

**Pass to RPh for evaluation if drug not in list.**

Immunosuppressive drugs include but are not limited to:

azathioprine	leflunomide
basiliximab	mercaptopurine
cyclophosphamide	methotrexate
cyclosporine	mycophenolate
etanercept	rituximab
everolimus	sirolimus
hydroxychloroquine	tacrolimus
infliximab	

**Yes:** Approve as follows: (immunocompromised patient)

### ORAL & TOPICAL

- Course of treatment.
- If length of therapy is unknown, approve for 3 months.

**No:** Go to #13

13. Is the request for treatment of a foot condition and does the member meet criteria for high-risk foot care?

Antifungals are funded when all of the following criteria are met:

- 1) The patient is at high risk for nail/foot complications due to severe circulatory insufficiency and/or areas of desensitization OR resides in an institutional setting (e.g., skilled nursing/rehabilitation facility, group home, etc)  
AND
- 2) There is clinical evidence of mycosis of the toenail;  
AND
- 3) The patient has documented marked limitation of ambulation, pain, and/or secondary bacterial infection resulting from the thickening and dystrophy of the infected toenail plate.

**Yes:** Approve as follows:

### ORAL & TOPICAL

- Course of treatment.
- If length of therapy is unknown, approve for 3 months.

Current age  $\geq$  21 years: Pass to RPh. Deny; not funded by the OHP

Current age < 21 years: Go to #14

14. Is there documentation that the condition is of sufficient severity that it impacts the patient's health (e.g., quality of life, function, growth, development, ability to participate in school, perform activities of daily living, etc)?

**Yes:** Go to #15

**No:** Pass to RPh. Deny; medical necessity.

## Approval Criteria

15. Is the request for a preferred product OR has the patient failed to have benefit with, or have contraindications or intolerance to, at least 2 preferred products?

**Message:**

Preferred products are evidence-based reviewed for comparative effectiveness and safety by the Oregon Pharmacy & Therapeutics Committee.

**Yes:** Approve for 12 months.

**No:** Pass to RPh. Deny; medical appropriateness.

Inform prescriber of covered alternatives in class and process appropriate PA.

16. RPh only: All other indications need to be evaluated to see if it is an OHP-funded diagnosis:

- If funded: may approve for treatment course with PRN renewals. If length of therapy is unknown, approve for 3-month intervals only.
- If not funded:
  - If current age < 21 years; Is there documentation that the condition is of sufficient severity that it impacts the patient's health (e.g., quality of life, function, growth, development, ability to participate in school, perform activities of daily living, etc)?
    - Is yes, may approve for treatment course with PRN renewals. If length of therapy is unknown, approve for 3-month intervals only.
    - If No, Deny (medical appropriateness)
  - If current age ≥ 21 years, Deny; not funded by the OHP.
    - Deny non-fungal diagnosis (medical appropriateness)
    - Deny fungal ICD-10 codes that do not appear on the OHP list pending a more specific diagnosis code (not funded by the OHP).
    - Forward any fungal ICD-10 codes not found in the Tables 1, 2, or 3 to the Lead Pharmacist. These codes will be forwarded to DMAP to be added to the Tables for future requests.

*P&T Review:* 12/23 (KS); 12/22; 2/22; 11/19; 7/15; 09/10; 2/06; 11/05; 9/05; 5/05  
*Implemented:* 1/1/24; 1/1/23; 4/1/22; 5/1/16; 8/15; 1/1/11; 7/1/06; 11/1/0; 9/1/0