# PRIOR AUTHORIZATION CRITERIA

**BRAND NAME***
**(generic)**

**SPORANOX ORAL CAPSULES**
**(itraconazole)**

***Status: CVS Caremark Criteria***
***Type: Initial Prior Authorization*** ***Ref # 280-A***

** Drugs that are listed in the target drug box include both brand and generic and all dosage forms and strengths unless otherwise stated. OTC products are not included unless otherwise stated.*

**FDA-APPROVED INDICATIONS**

Sporanox (itraconazole) Capsules are indicated for the treatment of the following fungal infections in immunocompromised and non-immunocompromised patients:
1. Blastomycosis, pulmonary and extrapulmonary
2. Histoplasmosis, including chronic cavitary pulmonary disease and disseminated, non-meningeal histoplasmosis, and
3. Aspergillosis, pulmonary and extrapulmonary, in patients who are intolerant of or who are refractory to amphotericin B therapy.

Specimens for fungal cultures and other relevant laboratory studies (wet mount, histopathology, serology) should be obtained before therapy to isolate and identify causative organisms. Therapy may be instituted before the results of the cultures and other laboratory studies are known; however, once these results become available, antiinfective therapy should be adjusted accordingly.

Sporanox Capsules are also indicated for the treatment of the following fungal infections in non-immunocompromised patients:
1. Onychomycosis of the toenail, with or without fingernail involvement, due to dermatophytes (tinea unguium), and
2. Onychomycosis of the fingernail due to dermatophytes (tinea unguium).

Prior to initiating treatment, appropriate nail specimens for laboratory testing (KOH preparation, fungal culture, or nail biopsy) should be obtained to confirm the diagnosis of onychomycosis.

Compendial Uses
Coccidioidomycosis[2,3]
Coccidioidomycosis prophylaxis in HIV infection[2,3]
Cryptococcosis[2,3]
Histoplasmosis prophylaxis in HIV infection[2,3]
Invasive fungal infection prophylaxis in liver transplant patients[3]
Microsporidiosis[2]
Talaromycosis (formerly Penicilliosis)[2]
Pityriasis versicolor/Tinea versicolor[3]
Sporotrichosis[2,3]
Tinea corporis, Tinea cruris, Tinea capitis, Tinea manuum, Tinea pedis[3]

**COVERAGE CRITERIA**

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has one of the following diagnoses: A) Pityriasis versicolor, B) Tinea versicolor, C) Onychomycosis due to dermatophytes (Tinea unguium) confirmed by a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy)
  **OR**
- The patient has one of the following diagnoses: A) Disseminated histoplasmosis, B) Central nervous system (CNS) histoplasmosis, C) Histoplasmosis prophylaxis in HIV infection, D) Coccidioidomycosis prophylaxis in HIV infection

**OR**

- The patient has one of the following diagnoses: A) Blastomycosis, B) Histoplasmosis, C) Aspergillosis, D) Coccidioidomycosis, E) Cryptococcosis, F) Sporotrichosis, G) Talaromycosis (formerly Penicilliosis), H) Microsporidiosis, I) Invasive fungal infection prophylaxis in a liver transplant patient

**OR**

- The patient has one of the following diagnoses: A) Tinea corporis, B) Tinea cruris, C) Tinea capitis, D) Tinea manuum, E) Tinea pedis

  **AND**

  - The patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following: A) fluconazole, B) griseofulvin, C) terbinafine

**RATIONALE**

The intent of the criteria is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. Sporanox (itraconazole) capsules are indicated for the treatment of blastomycosis, pulmonary and extrapulmonary; histoplasmosis, including chronic cavitary pulmonary disease and disseminated, non-meningeal histoplasmosis; and aspergillosis, pulmonary and extrapulmonary, in patients who are intolerant of or who are refractory to amphotericin B therapy. Specimens for fungal cultures and other relevant laboratory studies (wet mount, histopathology, serology) should be obtained before therapy to isolate and identify causative organisms. Therapy may be instituted before the results of the cultures and other laboratory studies are known; however, once these results become available, anti-infective therapy should be adjusted accordingly.[1] Acceptable compendia also indicate that itraconazole is appropriate for the treatment of coccidioidomycosis or coccidioidomycosis prophylaxis in HIV infection, cryptococcosis, histoplasmosis prophylaxis in HIV infection, invasive fungal infection prophylaxis in liver transplant patients, sporotrichosis, talaromycosis (formerly penicilliosis), and microsporidiosis.[2,3,7,8] Sporanox capsules are also indicated in non-immunocompromised patients for the treatment of onychomycosis of the toenail, with or without fingernail involvement, due to dermatophytes (tinea unguium); and onychomycosis of the fingernail due to dermatophytes (tinea unguium). Prior to initiating treatment, appropriate nail specimens for laboratory testing (potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy) should be obtained to confirm the diagnosis of onychomycosis.[1] Per the compendia, itraconazole is suggested as an alternative therapy for the treatment of pityriasis versicolor, tinea versicolor, tinea corporis, tinea cruris, tinea capitis, tinea manuum or tinea pedis.[2,3]

Itraconazole will be approved for the treatment of onychomycosis due to dermatophytes (tinea unguium) following confirmation with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy). Itraconazole will be approved for the treatment of patients with either pityriasis versicolor or tinea versicolor. Itraconazole will be approved for the treatment of blastomycosis, histoplasmosis, aspergillosis, coccidioidomycosis, cryptococcosis, sporotrichosis, talaromycosis (formerly penicilliosis), and microsporidiosis.

Griseofulvin is used in the treatment of tineas (ringworm infections) of the skin, hair, and nails, including tinea barbae, tinea capitis, tinea corporis, tinea cruris, and tinea pedis.[2] According to the American Academy of Family Physicians, griseofulvin has been the first-line treatment for tinea capitis infections for many years due to its long track record of safety and effectiveness. However, randomized clinical trials have confirmed that newer agents, such as terbinafine and fluconazole, have equal effectiveness and safety and shorter treatment courses.[9] Once-weekly administration of 150 mg fluconazole has compendial support in patients with tinea corporis, tinea cruris, and tinea pedis.[3] Oral terbinafine is a first-line agent for tinea capitis because of its tolerability, high cure rate, and low cost. Culture results are usually not available for two to six weeks, but 95% of tinea capitis cases in the United States are caused by Trichophyton, making terbinafine a reasonable first choice. Common treatment options for tinea capitis include griseofulvin, terbinafine, fluconazole, and itraconazole.[9] Terbinafine also has compendial support for tinea cruris and tinea corporis.[2] Itraconazole will be approved for the treatment of tinea corporis, tinea cruris, tinea capitis, tinea manuum or tinea pedis following an inadequate treatment response or intolerance to fluconazole, griseofulvin or terbinafine or for patients who have a contraindication to any of these alternative therapies.

The AHFS DI compendium states that the usual duration of treatment for disseminated histoplasmosis is at least 12 months. It also states that discontinuance of secondary prophylaxis against coccidioidomycosis can be considered after 12 months in HIV-infected adults and adolescents. Additionally, consideration can be given to discontinuing secondary prophylaxis in HIV-infected adults and adolescents who have negative Histoplasma blood cultures, have serum

Histoplasma antigen levels less than 2 ng/mL, have received itraconazole for at least 12 months, have been receiving antiretroviral therapy for at least 6 months, and have CD4+ T-cell counts of 150/mm3 or greater.[2] Micromedex states that the recommended dose of itraconazole for CNS histoplasmosis (meningitis, parenchymal lesions of the brain and/or spinal cord, or both) after initial therapy with liposomal amphotericin B for 4 to 6 weeks, is 200 milligrams orally two or three times daily for at least 1 year and until resolution of cerebrospinal fluid abnormalities, including Histoplasma antigen.[3] Both compendiums list disseminated histoplasmosis as an FDA-approved use with a recommendation for therapy to continue for at least 12 months.[2,3] Therefore, the duration of approval for disseminated histoplasmosis, CNS histoplasmosis, coccidioidomycosis prophylaxis in HIV infection and histoplasmosis prophylaxis in HIV infection will be set at 12 months. The recommended treatment course for onychomycosis of the toenails, with or without fingernail involvement, is 200 mg once daily for 12 weeks.[1] The suggested dosing for superficial tinea infections is similar to that of onychomycosis of the toenails, 200 mg once daily, although for a shorter duration.[3] Therefore, coverage for these conditions will be approved for up to 3 months. The recommended and suggested treatments for the remainder of the approvable indications vary depending on the type of infection and patient specific factors. Treatment in life-threatening situations should be continued for a minimum of 3 months and until clinical parameters and laboratory tests indicate that the active fungal infection has subsided. An inadequate period of treatment may lead to recurrence of active infection.[1] Therefore, the duration of approval for these indications will be set at 6 months.

## REFERENCES


1. Sporanox capsule [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc.; December 2019.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: Wolters Kluwer Clinical Drug Information, Inc. http://online.lexi.com/. Accessed February 2020.
3. Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. http://www.micromedexsolutions.com/. Accessed February 2020.
4. Patterson TF, Thompson GR, Denning DW, et al. Practice Guidelines for the Diagnosis and Management of Aspergillosis: 2016 Update by the Infectious Diseases Society of America. *Clinical Infectious Diseases*. 2016;63:112–146.
5. Wheat L, Freifeld A, Kleiman M, et al. Clinical Practice Guidelines for the Management of Patients with Histoplasmosis: 2007 Update by the Infectious Diseases Society of America. *Clinical Infectious Diseases*. 2007;45:807–25.
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7. Perfect J, Dismukes W, Dromer F, et al. Clinical Practice Guidelines for the Management of Cryptococcal Disease: 2010 Update by the Infectious Diseases Society of America. *Clinical Infectious Diseases*. 2010;50:291–322.
8. Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf. Accessed February 2020.
9. Ely, JW, Rosenfeld, S, Stone, MS. Diagnosis and Management of Tinea Infections. American Family Physician 2014;90(10):702-712.


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## CRITERIA FOR APPROVAL

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|---|---|---|---|
| 1 | Does the patient have one of the following diagnoses: A) Pityriasis versicolor, B) Tinea versicolor, C) Onychomycosis due to dermatophytes (Tinea unguium) confirmed by a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy)? | Yes | No |

[If yes, then no further questions.]

| | | | |
|---|---|---|---|
| 2 | Does the patient have one of the following diagnoses: A) Tinea corporis, B) Tinea cruris, C) Tinea capitis, D) Tinea manuum, E) Tinea pedis?<br>[If no, then skip to question 4.] | Yes | No |
| 3 | Has the patient experienced an inadequate treatment response, intolerance or contraindication to any of the following: A) fluconazole, B) griseofulvin, C) terbinafine?<br>[No further questions.] | Yes | No |
| 4 | Does the patient have one of the following diagnoses: A) Disseminated histoplasmosis, B) Central nervous system (CNS) histoplasmosis, C) Histoplasmosis prophylaxis in HIV infection, D) Coccidioidomycosis prophylaxis in HIV infection?<br>[If yes, then no further questions.] | Yes | No |
| 5 | Does the patient have one of the following diagnoses: A) Blastomycosis, B) Histoplasmosis, C) Aspergillosis, D) Coccidioidomycosis, E) Cryptococcosis, F) Sporotrichosis, G) Talaromycosis (formerly Penicilliosis), H) Microsporidiosis, I) Invasive fungal infection prophylaxis in a liver transplant patient? | Yes | No |

| Mapping Instructions | | | |
|---|---|---|---|
| | **Yes** | **No** | **DENIAL REASONS – DO NOT USE FOR MEDICARE PART D** |
| 1. | Approve, 3 months | Go to 2 | |
| 2. | Go to 3 | Go to 4 | |
| 3. | Approve, 3 months | Deny | You do not meet the requirements of your plan.<br>Your plan covers this drug when you have these conditions:<br>- You have a fungal infection of the groin, scalp, or hand, or athlete's foot<br>- You have tried fluconazole, griseofulvin, or terbinafine and it did not work for you, or you cannot use it<br>Your request has been denied based on the information we have.<br>[Short Description: No approvable diagnosis, no inadequate response, intolerance or contraindication to fluconazole, griseofulvin, terbinafine] |
| 4. | Approve, 12 months | Go to 5 | |
| 5. | Approve, 6 months | Deny | You do not meet the requirements of your plan.<br>Your plan covers this drug when you have one of these conditions:<br>- You have a fungal infection of the groin, scalp, hands, or feet<br>- You have a specific fungal infection of the skin that causes spots<br>- You have a specific nail fungus and it has been tested<br>- You have Blastomycosis, Histoplasmosis, Aspergillosis, Coccidioidomycosis, Cryptococcosis, Sporotrichosis, Talaromycosis (formerly Penicilliosis) or Microsporidiosis<br>- You have HIV and are preventing Histoplasmosis or Coccidioidomycosis<br>- You have had a liver transplant and are preventing a fungal infection<br>Your request has been denied based on the information we have.<br>[Short Description: No approvable diagnosis, no confirmation of diagnosis] |