PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

SPORANOX ORAL SOLUTION
(itraconazole)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Sporanox (itraconazole) Oral Solution is indicated for the treatment of oropharyngeal and esophageal candidiasis.

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

- The requested drug is being prescribed for the treatment of oropharyngeal candidiasis or esophageal candidiasis

AND

- The patient has experienced an inadequate treatment response to fluconazole
  OR
- The patient has experienced an intolerance to fluconazole
  OR
- The patient has a contraindication that would prohibit a trial of fluconazole

REFERENCES

1. Sporanox Oral Solution [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc.; April 2019.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: UpToDate, Inc. 2021. Accessed February 2, 2022.
3. Micromedex (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: https://www.micromedexsolutions.com. Accessed January 18, 2022.
4. Pappas P, Kauffman C, Andes D, et al. Clinical Practice Guidelines for the Management of Candidiasis: 2016 Update by the Infectious Diseases Society of America. *Clinical Infectious Diseases*. 2016;62:1-50**.**