

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.; December 2023.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: UpToDate, Inc. 2023. Accessed February 6, 2023.
3. Micromedex (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: <https://www.micromedexsolutions.com>. Accessed February 6, 2023.
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.