Effective Date:01/01/2022
Reviewed: 10/2021, 9/2022, 3/2023, 3/2024, 5/2025 Scope: Medicaid

Voriconazole tablets

POLICY

I. CRITERIA FOR APPROVAL

An authorization may be granted when all the following criteria are met:

A. Patient is 2 years or older; AND
B. Patient has documented diagnosis of an invasive aspergillus infection; OR
C. Patient has documented diagnosis of a serious infection caused by scedosporium and fusarium species; OR
D. Patient has documented diagnosis of esophageal candidiasis or oropharyngeal candidiasis; AND documented failure of or clinical inappropriateness to fluconazole and itraconazole; OR
E. Patient has documented diagnosis of candidemia and disseminated candidiasis infections AND documented failure of or clinical inappropriateness to oral fluconazole; OR
F. Documented diagnosis of prevention of invasive aspergillus and candida fungal infections AND documentation of hematologic malignancy with neutropenia, hematopoietic stem cell transplant, or graft-versus-host disease.

II. COVERAGE DURATION

- 6 months

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