Clinical Policy: Antifungals, Topical

Reference Number: PHW.PDL.061
Effective Date: 01/01/2020
Last Review Date: 11/2023

Revision Log

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of PA Health and Wellness® that Topical Antifungals are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antifungals, Topical

A. Prescriptions That Require Prior Authorization

A prescription for a non-preferred Antifungal, Topical must be prior authorized.

See the Preferred Drug List (PDL) for the list of preferred Antifungals, Topical at: https://papdl.com/preferred-drug-list.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antifungal, Topical, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. For a non-preferred Antifungals, Topical, has a history of a contraindication, intolerance to, or therapeutic failure of the preferred Antifungals, Topical approved or medically accepted for the member's diagnosis or indication.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guideline in Section B. above, to assess the medical necessity of the request for a prescription for a non-preferred Antifungal, Topical. If the guideline in Section B is met, the reviewer will prior authorize the prescription. If the guideline is not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the

professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

D. **<u>Approval Duration</u>:**
   - **Duration of request or 6 months (whichever is less)**

E. <u>References:</u>

1. UpToDate – "Onychomycosis" accessed 04/24/15
2. Ciclopirox prescribing information.
3. Jublia prescribing information. Valeant Pharmaceuticals North America LLC. February 2015
4. Kerydin prescribing information. Anacor Pharmaceuticals, Inc. July 2014.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022: policy revised according to DHS revisions effective 01/03/2022	10/2021
Q1 2023 annual review: no changes.	11/2022
Q1 2024 annual review: no changes.	11/2023