Clinical Policy: Antifungals, Oral

Reference Number: PHW.PDL.069
Effective Date: 01/01/2020
Last Review Date: 11/2024

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 Oral Antifungals are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antifungals, Oral

A. Prescriptions That Require Prior Authorization

Prescriptions for Antifungals, Oral that meet any of the following conditions must be prior authorized:

1. A non-preferred Antifungal, Oral.

2. An Antifungal, Oral with a prescribed quantity that exceeds the quantity limit.

B. Review of Documentation for Medical Necessity

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

1. For a non-preferred Antifungal, Oral, **one** of the following:

   a. Has a history of therapeutic failure, contraindication, or intolerance to the preferred Antifungals, Oral approved or medically accepted for the member's diagnosis
   b. Has culture and sensitivity test results documenting that only a non-preferred Antifungal, Oral will be effective;

AND

2. If a prescription for an Antifungal, Oral is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

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 guidelines in Section B. above to assess the medical necessity of a prescription for an Antifungal, Oral. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are 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 member.

D. **Approval Duration: 6 months**

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 annual review: no changes.	11/2021
Q1 2023 annual review: no changes.	11/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: no changes.	11/2024