

PRIOR AUTHORIZATION CRITERIA

DRUG CLASS	ITRACONAZOLE SOLUTION
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:

- Patient has a diagnosis of oropharyngeal candidiasis or esophageal candidiasis.

REFERENCES

1. Sporanox Oral Solution [package insert]. Raritan, NJ: Janssen Pharmaceuticals, Inc.; October 2016.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed April 2017.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed April 2017.
4. Pappas P, Kauffman C, Andes D, et al. Clinical Practice Guidelines for the Management of Candidiasis: 2009 Update by the Infectious Diseases Society of America. *Clinical Infectious Diseases*. 2009;48:503–35.