AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Voriconazole	Page:	1 of 3
Effective Date:	6/26/2024	Last Review Date:	6/5/2024

Applies to:	☒Illinois	☐Florida	☒New Jersey
	☒Maryland	☒Florida Kids	☒Pennsylvania Kids
	☐Michigan	☐ Virginia	

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Voriconazole under the patient's prescription drug benefit.

Description:

Invasive Aspergillosis
Voriconazole is indicated in adults and pediatric patients (2 years of age and older) for the treatment of invasive aspergillosis (IA). In clinical trials, the majority of isolates recovered were *Aspergillus fumigatus*. There was a small number of cases of culture-proven disease due to species of *Aspergillus* other than *A. fumigatus*.

Candidemia in Non-neutropenic Patients and Other Deep Tissue Candida Infections
Voriconazole is indicated in adults and pediatric patients (2 years of age and older) for the treatment of candidemia in non-neutropenic patients and the following *Candida* infections: disseminated infections in skin and infections in abdomen, kidney, bladder wall, and wounds.

Esophageal Candidiasis
Voriconazole is indicated in adults and pediatric patients (2 years of age and older) for the treatment of esophageal candidiasis (EC) in adults and pediatric patients 2 years of age and older.

Scedosporiosis and Fusariosis
Voriconazole is indicated for the treatment of serious fungal infections caused by *Scedosporium apiospermum* (asexual form of *Pseudallescheria boydii*) and *Fusarium spp*. including *Fusarium solani*, in adults and pediatric patients (2 years of age and older) intolerant of, or refractory to, other therapy.

Specimens for fungal culture and other relevant laboratory studies (including histopathology) should be obtained prior to therapy to isolate and identify causative organism(s). Therapy may be instituted before the results of the cultures and other laboratory studies are known. However, once these results become available, antifungal therapy should be adjusted accordingly.

Compendial Uses
Febrile Neutropenia, Empiric Antifungal Therapy, High-Risk Patients
Invasive Aspergillosis, Prophylaxis, High-Risk Patients
Mycosis, Due to *Scedosporium prolificans*
Oropharyngeal Candidiasis
Pulmonary Aspergillosis, Chronic

Applicable Drug List:

Preferred Agent:
Voriconazole 50mg and 200mg tablets

Non-Preferred Agent:
Voriconazole Suspension

Policy/Guideline:

Criteria for Initial Approval:

I. The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for any of the following: A) treatment of invasive aspergillosis (including invasive pulmonary aspergillosis), B) serious fungal infection caused by Scedosporium apiospermum and Fusarium species, C) prophylaxis of invasive aspergillosis in a high-risk patient, D) chronic pulmonary aspergillosis, E) empiric antifungal therapy for febrile neutropenia in a high-risk patient, F) mycosis due to Scedosporium prolificans

OR

- The requested drug is being prescribed for any of the following: A) candidemia in a non-neutropenic patient, B) disseminated Candida infection in the skin, C) Candida infection in the abdomen, kidney, bladder wall, or wounds, D) esophageal candidiasis, E) oropharyngeal candidiasis

  AND
- The patient has experienced an inadequate treatment response to an alternative antifungal therapy

  OR
- The patient has experienced an intolerance to an alternative antifungal therapy

  OR
- The patient has a contraindication that would prohibit a trial of an alternative antifungal therapy

AND

- The patient will use the requested drug orally or intravenously

AND

- If the request is for voriconazole powder for oral suspension, the patient meets one of the following: A) has difficulty swallowing solid oral dosage forms (e.g., tablets), B) requires a dose that cannot be obtained using the commercially available tablets

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 6 month

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

1. Vfend [package insert]. New York, New York: Roerig, Division of Pfizer Inc.; October 2022.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2023. https://online.lexi.com. Accessed December 10, 2023.
3. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 12/10/2023).
4. Centers for Disease Control and Prevention. Fungal Diseases. Available at: https://www.cdc.gov/fungal/diseases/aspergillosis/definition.html. Accessed December 10, 2023.
5. Pappas PG, Kauffman CA, Andes DR, et al. Clinical Practice Guideline for the Management of Candidiasis: 2016 Update by the Infectious Diseases Society of America. *Clin Infect Dis* 2016;62(4):e1-50.
6. Patterson TF, Thompson III GR, Denning DW, et al. Practice Guidelines for the Diagnosis and Management of Aspergillosis: 2016 Update by the Infectious Diseases Society of America. *Clin Infect Dis* 2016;63(4):e1-60.
7. Stevens DL, Bisno AL, Chambers HF, et al. Practice Guidelines for the Diagnosis and Management of Skin and Soft Tissue Infections: 2014 Update by the Infectious Diseases Society of America. *Clin Infect Dis* 2014;59(2):e10-52.
8. Freifeld AG, Bow EJ, Sepkowitz KA et al. Clinical Practice Guideline for the Use of Antimicrobial Agents in Neutropenic Patients with Cancer: 2010 Update by the Infectious Diseases Society of America. *Clin Infect Dis* 2011:52(4):e56-93.