Clinical Policy: Itraconazole (Sporanox, Tolsura)

Reference Number: CP.PMN.124
Effective Date: 11.01.06
Last Review Date: 05.25
Line of Business: Commercial, HIM, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Itraconazole (Sporanox®, Tolsura®) is an azole antifungal agent.

FDA Approved Indication(s)

Sporanox and Tolsura capsules are indicated in:

- Immunocompromised and non-immunocompromised patients for the treatment of:
  - Blastomycosis, pulmonary and extrapulmonary
  - Histoplasmosis, including chronic cavitary pulmonary disease and disseminated, nonmeningeal histoplasmosis
  - Aspergillosis, pulmonary and extrapulmonary, in patients who are intolerant of or who are refractory to amphotericin B therapy

Sporanox capsules are additionally indicated in:

- Non-immunocompromised patients for the treatment of:
  - Onychomycosis of the toenail, with or without fingernail involvement, due to dermatophytes (tinea unguium)
  - Onychomycosis of the fingernail due to dermatophytes (tinea unguium)

Sporanox oral solution is indicated for the treatment of oropharyngeal and esophageal candidiasis.

Limitation(s) of use: Tolsura is not indicated for the treatment of onychomycosis. Tolsura is not interchangeable or substitutable with other itraconazole products.

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 health plans affiliated with Centene Corporation® that itraconazole, Sporanox, and Tolsura are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Onychomycosis (must meet all)**:**

1. Diagnosis of onychomycosis;
2. Request is for Sporanox capsules or itraconazole capsules;
3. If request is for brand Sporanox, member must use generic itraconazole capsules, unless contraindicated or clinically significant adverse effects are experienced;

4. Member meets one of the following (a or b)*:
   **For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395.*
   a. For fingernail disease: Failure of a 6-week trial of oral terbinafine at 250 mg per day, unless contraindicated or clinically significant adverse effects are experienced;
   b. For toenail disease: Failure of a 12-week trial of oral terbinafine at 250 mg per day, unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed 400 mg (4 capsules) per day.

Approval duration: Fingernail disease: 2 months; toenail disease: 3 months

B. Oropharyngeal Candidiasis (must meet all)**:**
1. Diagnosis of oropharyngeal candidiasis;
2. Request is for Sporanox oral solution or itraconazole oral solution;
3. If request is for brand Sporanox, member must use generic itraconazole oral solution, unless contraindicated or clinically significant adverse effects are experienced;
4. Failure of a 7-day trial of nystatin suspension or clotrimazole troches/lozenges, unless clinically significant adverse effects are experienced or both are contraindicated;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395.*
5. Failure of a 7-day trial of fluconazole, unless contraindicated or clinically significant adverse effects are experienced;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395.*
6. Dose does not exceed 200 mg (20 mL) per day.

Approval duration: 4 weeks

C. Esophageal Candidiasis (must meet all)**:**
1. Diagnosis of esophageal candidiasis;
2. Request is for Sporanox oral solution or itraconazole oral solution;
3. If request is for brand Sporanox, member must use generic itraconazole oral solution, unless contraindicated or clinically significant adverse effects are experienced;
4. Failure of a 14-day trial of fluconazole at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395.*
5. Dose does not exceed 200 mg (20 mL) per day.

Approval duration: 4 weeks

D. Aspergillosis (must meet all)**:**
1. Diagnosis of aspergillosis;
2. Request is for Sporanox capsules, Tolsura, or itraconazole capsules;
3. If request is for brand Sporanox or Tolsura, member must use generic itraconazole capsules, unless contraindicated or clinically significant adverse effects are experienced;
4. Failure of a 3-month trial of voriconazole^ at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;*

^*Prior authorization may be required for voriconazole*
**For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395.*

5. Dose does not exceed one of the following (a or b):
   a. Itraconazole or Sporanox capsules: 400 mg (4 capsules) per day;
   b. Tolsura capsules: 260 mg (4 capsules) per day.

Approval duration: 3 months

E. Blastomycosis or Histoplasmosis (must meet all)**:**
1. Diagnosis of blastomycosis or histoplasmosis;
2. Request is for Sporanox capsules, Tolsura, or itraconazole capsules;
3. If request is for brand Sporanox or Tolsura, member must use generic itraconazole capsules, unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed one of the following (a or b):
   a. Itraconazole or Sporanox capsules: 400 mg (4 capsules) per day;
   b. Tolsura capsules: 260 mg (4 capsules) per day.

Approval duration: Blastomycosis: 6 months; Histoplasmosis: 6 weeks

F. Hematologic Malignancy (off-label) (must meet all)**:**
1. Diagnosis of hematologic malignancy;
2. Member must use generic itraconazole capsules or oral solution, unless contraindicated or clinically significant adverse effects are experienced;
3. Member meets one of the following (a or b):
   a. Request is for prophylaxis of aspergillosis;
   b. Request is for prophylaxis of candidiasis, and member has failed fluconazole at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed one of the following (a, b, or c):
   a. Itraconazole or Sporanox capsules: 400 mg (4 capsules) per day;
   b. Itraconazole or Sporanox oral solution: 200 mg (20 mL) per day;
   c. Tolsura capsules: 260 mg (4 capsules) per day.

Approval duration: 3 months

G. Coccidioidomycosis (off-label) (must meet all)**:**
1. Diagnosis of coccidioidomycosis infection, and member is infected with one of the following (a, b, or c):
   a. HIV-1, and member has peripheral blood CD4 < 250 cells/mm^3;
   b. Focal pulmonary disease;
   c. Disseminated extrathoracic nonmeningeal or meningeal coccidioidomycosis;
2. Request is for Sporanox or itraconazole capsules or oral solution;
3. Prescribed by or in consultation with an infectious disease specialist, pulmonologist, or HIV specialist;
4. If request is for brand Sporanox, member must use generic itraconazole capsules or oral solution, unless contraindicated or clinically significant adverse effects are experienced;

5. Failure of fluconazole at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395.*
6. Dose does not exceed one of the following (a, b, or c):
   a. For disseminated extrathoracic nonmeningeal or meningeal coccidioidomycosis (i or ii):
      i. Capsules: 600 mg (6 capsules) per day;
      ii. Oral solution: 600 mg (60 mL) per day;
   b. For coccidioidomycosis with HIV-1 co-infection (i or ii):
      i. Capsules: 600 mg (6 capsules) per day for the first three days, then 400 mg (4 capsules) per day thereafter;
      ii. Oral solution: 600 mg (60 mL) per day for the first three days, then 400 mg (40 mL) per day thereafter;
   c. For all other coccidioidomycosis infections (i or ii):
      i. Capsules: 400 mg (4 capsules) per day;
      ii. Oral solution: 400 mg (40 mL) per day.

Approval duration: 6 months

H. Sporotrichosis (off-label) (must meet all)**:**
1. Diagnosis of sporotrichosis infection, and member is infected with one of the following (a or b):
   a. Lymphocutaneous, cutaneous, non-severe pulmonary or osteoarticular sporotrichosis;
   b. Severe pulmonary, meningeal, or disseminated systemic sporotrichosis;
2. Request is for Sporanox or itraconazole capsules or oral solution;
3. Prescribed by or in consultation with an infectious disease specialist or pulmonologist;
4. If request is for brand Sporanox, member must use generic itraconazole capsules or oral solution, unless contraindicated or clinically significant adverse effects are experienced;
5. For severe pulmonary, meningeal, or disseminated systemic sporotrichosis: Previous use of amphotericin B, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed one of the following (a or b):
   a. Capsules: 400 mg (4 capsules) per day;
   b. Oral solution: 400 mg (40 mL) per day.

Approval duration: 12 months

I. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Onychomycosis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. Request is for Sporanox oral capsules or itraconazole capsules;
4. If request is for brand Sporanox, member must use generic itraconazole capsules, unless contraindicated or clinically significant adverse effects are experienced;
5. Member has not received more than 90 days of treatment;
6. If request is for a dose increase, new dose does not exceed 400 mg (4 capsules) per day.

Approval duration: Fingernail disease: up to 2 months total; toenail disease: up to 3 months total

B. Oropharyngeal/Esophageal Candidiasis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. Request is for Sporanox oral solution or itraconazole oral solution;
4. If request is for brand Sporanox, member must use generic itraconazole oral solution, unless contraindicated or clinically significant adverse effects are experienced;
5. If request is for a dose increase, new dose does not exceed 200 mg (20 mL) per day.

Approval duration: 2 weeks

C. Blastomycosis, Histoplasmosis, or Aspergillosis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*

2. Member is responding positively to therapy;
3. Request is for Sporanox oral capsules, Tolsura, or itraconazole capsules;
4. If request is for brand Sporanox, member must use generic itraconazole capsules, unless contraindicated or clinically significant adverse effects are experienced;
5. If request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. Itraconazole or Sporanox capsules: 400 mg (4 capsules) per day;
   b. Tolsura capsules: 260 mg (4 capsules) per day.

Approval duration: Blastomycosis: 6 months; Histoplasmosis: 6 weeks; Aspergillosis: 3 months

D. Hematologic Malignancy (off-label) (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member must use generic itraconazole capsules or oral solution, unless contraindicated or clinically significant adverse effects are experienced;
3. Member is responding positively to therapy;
4. If request is for a dose increase, new dose does not exceed one of the following (a, b, or c):
   a. Itraconazole or Sporanox capsules: 400 mg (4 capsules) per day;
   b. Itraconazole or Sporanox oral solution: 200 mg (20 mL) per day;
   c. Tolsura capsules: 260 mg (4 capsules) per day.

Approval duration: 6 months

E. Coccidioidomycosis (off-label) (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Request is for Sporanox or itraconazole capsules or oral solution;
3. If request is for brand Sporanox, member must use generic itraconazole capsules or oral solution, unless contraindicated or clinically significant adverse effects are experienced;
4. If HIV-1 positive, member has peripheral blood CD4 < 250 cells/mm^3;

5. If request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. For disseminated extrathoracic nonmeningeal or meningeal coccidioidomycosis (i or ii):
      i. Capsules: 600 mg (6 capsules) per day;
      ii. Oral solution: 600 mg (60 mL) per day;
   b. For all other coccidioidomycosis infections (i or ii):
      i. Capsules: 400 mg (4 capsules) per day;
      ii. Oral solution: 400 mg (40 mL) per day.

Approval duration: 12 months

F. Sporotrichosis (off-label) (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Request is for Sporanox or itraconazole capsules or oral solution;
3. If request is for brand Sporanox, member must use generic itraconazole capsules or oral solution, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. Capsules: 400 mg (4 capsules) per day;
   b. Oral solution: 400 mg (40 mL) per day.

Approval duration: 12 months

G. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CHF: congestive heart failure
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
terbinafine (Lamisil®)	Onychomycosis: 250 mg PO QD	500 mg per day
nystatin suspension	Oropharyngeal candidiasis: 400,000 to 600,000 units (4 to 6 mL) per dose swished in the mouth QID	2.4 million units per day
clotrimazole troches/ lozenges	Oropharyngeal candidiasis: 10 mg troche PO 5 times daily for 14 days	Varies
fluconazole (Diflucan®)	Oropharyngeal candidiasis: 100 to 200 mg PO QD for 7 to 14 days Esophageal candidiasis: 200 to 400 mg PO per day for 14 to 21 days Coccidioidomycosis: 400 mg PO QD	See dosing regimen
voriconazole (Vfend®)	Aspergillosis: Weight ≥ 40 kg: 200 mg PO every 12 hours Weight < 40 kg: 100 mg PO every 12 hours	Weight ≥ 40 kg: 800 mg per day Weight < 40 kg: 400 mg per day
amphotericin B	Sporotrichosis: Adults: 0.7 to 1 mg/kg/dose IV every 24 hours until favorable response. Continue step-down therapy with itraconazole to complete a total of at least 12 months of therapy	1 – 1.5 mg/kg/day IV

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Itraconazole should not be administered to patients with evidence of ventricular dysfunction such as congestive heart failure (CHF) or a history of CHF:

        - For the treatment of onychomycosis (Sporanox capsules only)
        - Except for the treatment of life-threatening or other serious infections (Sporanox oral solution only)
    - Concomitant coadministration of itraconazole with certain drugs that are metabolized by human CYP3A4 substrates, some examples include the following drugs: methadone, disopyramide, dofetilide, dronedarone, quinidine, isavuconazole, ergot alkaloids (such as dihydroergotamine, ergometrine (ergonovine), ergotamine, methylergometrine (methylergonovine)), irinotecan, lurasidone, oral midazolam, pimozide, triazolam, felodipine, nisoldipine, ivabradine, ranolazine, eplerenone, naloxegol, lomitapide, lovastatin, simvastatin, avanafil, ticagrelor
    - Coadministration with eliglustat in subjects that are poor or intermediate metabolizers of CYP2D6 or subjects taking strong or moderate CYP2D6 inhibitors
    - Coadministration with colchicine, fesoterodine, and solifenacin in subjects with varying degrees of renal or hepatic impairment
    - Additional product-specific drug-drug interactions include:
        - Sporanox (capsules and oral solution): cisapride, finerenone, voclosporin
    - Hypersensitivity and anaphylaxis to itraconazole
- Boxed warning(s):
    - CHF or history of CHF (see contraindications)
    - Drug-drug interactions (see contraindications)

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Itraconazole (Sporanox) capsule	Blastomycosis	200 mg PO QD	400 mg/day
	Histoplasmosis	200 mg PO QD	400 mg/day
	Aspergillosis	200 to 400 mg PO QD	400 mg/day
	Onychomycosis	Toenails with or without fingernail involvement: 200 mg PO QD for 12 weeks Fingernails only: 200 mg PO BID for 1 week, followed by no drug for 3 weeks, then another week of 200 mg PO BID or 200 mg PO QD for 6 weeks*	400 mg/day
	Coccidioidomycosis*	200 mg PO BID or 200 mg BID-TID for nonmeningeal or meningeal coccidioidomycosis In patients co-infected with HIV: Adults: 200 mg PO TID for the first 3 days, then 200 mg PO BID Pediatrics: 5-10 mg/kg PO BID for the first 3 days, then 2-5 mg/kg PO BID	600 mg/day

Drug Name	Indication	Dosing Regimen	Maximum Dose
	Lymphocutaneous or cutaneous sporotrichosis*	200 mg PO QD for 3-6 months. If no response then increase to 200 mg PO BID.	400 mg/day
	Osteoarticular, pulmonary, meningeal, or disseminated systemic sporotrichosis*	200 mg PO BID for at least 12 months	400 mg/day
	In life-threatening situations	Loading dose of 200 mg PO TID given for the first 3 days of treatment	600 mg/day
Itraconazole (Sporanox) oral solution	Oropharyngeal candidiasis	200 mg (20 mL) PO daily for 1 to 2 weeks; swish in the mouth (10 mL at a time) for several seconds and swallow	200 mg (20 mL)/day
	Esophageal candidiasis	100 mg (10 mL) PO daily for a minimum treatment of three weeks. Treatment should continue for 2 weeks following resolution of symptoms.	200 mg (20 mL)/day
	Coccidioidomycosis*	200 mg (20 mL) PO BID or 200 mg (20 mL) BID-TID for nonmeningeal or meningeal coccidioidomycosis In patients co-infected with HIV: Adults: 200 mg PO TID for the first 3 days, then 200 mg PO BID Pediatrics: 5-10 mg/kg PO BID for the first 3 days, then 2-5 mg/kg PO BID	600 mg (60 mL)/day
	Lymphocutaneous or cutaneous sporotrichosis*	200 mg (20 mL) PO QD for 3-6 months. If no response then increase to 200 mg PO BID.	400 mg (40 mL)/day
	Osteoarticular, pulmonary, meningeal, or disseminated systemic sporotrichosis*	200 mg (20 mL) PO BID for at least 12 months	400 mg (40 mL)/day
Itraconazole (Tolsura)	Blastomycosis, histoplasmosis	130 mg PO QD. Increase dose if no obvious improvement or evidence of progressive fungal disease in 65	260 mg/day

Drug Name	Indication	Dosing Regimen	Maximum Dose
		mg increments. Doses above 130 mg/day should be given in divided doses.	
	Aspergillosis	130 mg PO QD or BID	260 mg/day
	In life-threatening situations	Loading dose of 130 mg TID QD for the first 3 days of treatment	390 mg/day

**Off-label*

VI. Product Availability

Drug Name	Availability
Itraconazole (Sporanox)	Capsule: 100 mg Oral solution: 10 mg/mL
Itraconazole (Tolsura)	Capsule: 65 mg

VII. References

1. Sporanox Oral Solution Prescribing Information. Titusville, NJ: Janssen Pharmaceuticals, Inc.; December 2024. Available at: https://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/SPORANOX-Oral+Solution-pi.pdf. Accessed January 21, 2025.
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9. Ameen M, Lear JT, Madan V, et al. British Association of Dermatologists' guidelines for the management of onychomycosis 2014. *Br J Dermatology.* 2014;171:937-58.
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11. Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at: https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/whats-new-guidelines. Updated December 16, 2024. Accessed February 4, 2025.
12. Panel on Opportunistic Infections in HIV-Exposed and HIV-Infected Children. Guidelines for the prevention and treatment of opportunistic infections in children with and exposed to HIV. Department of Health and Human Services. Available at: https://clinicalinfo.hiv.gov/en/guidelines/pediatric-opportunistic-infection/whats-new. Updated November 21, 2024. Accessed February 4, 2025.
13. Kauffman C, Bustamante B, Chapman S, et al. Clinical practice guidelines for the management of sporotrichosis: 2007 update by the Infectious Diseases Society of America. *Clin Infect Dis*. 2007; 45:1255-65.
14. Fungal diseases: Sporotrichosis. Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/fungal/diseases/sporotrichosis/index.html. Last updated: February 9, 2022. Accessed January 30, 2024.
15. Galgiani JN, Ampel NM, Blair JE, et al. 2016 Infectious Diseases Society of America (IDSA) clinical practice guideline for the treatment of coccidioidomycosis. Clinical Infectious Diseases. *Clin Infect Dis*. 2016; 63(6): e112–e146.
16. Taplitz RA, Kennedy EB, Bow EJ, et al. Antimicrobial prophylaxis for adult patients with cancer-related immunosuppression: ASCO and IDSA clinical practice guideline update. *J Clin Oncol.* 2018; 36(30): 3043-3054.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: no significant changes; removed Onmel from policy since it is no longer available (MediSpan obsolete date of August 2020); removed references to HIM.PA.103; clarified the specific agents that should be used if the preferred generic is unable to be used; revised "medical justification" to "must use" language; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	01.12.21	05.21
2Q 2022 annual review: no significant changes; updated max dosing for coccidioidomycosis infection per compendia, including addition of HIV-specific dosing; references reviewed and updated.	01.25.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.03.22	
2Q 2023 annual review: per IDSA dosing recommendations reduced trial duration of fluconazole for oropharyngeal candidiasis from 14 to 7 days, for esophageal candidiasis from 21 to 14 days, for oropharyngeal candidiasis reduced nystatin suspension or clotrimazole troches/lozenges trial duration from 14 to 7 days; clarified in Appendix C contraindication in women who are	01.31.23	05.23

Reviews, Revisions, and Approvals	Date	P&T Approval Date
pregnant or contemplating pregnancy applies only for the treatment of onychomycosis; references reviewed and updated.		
2Q 2024 annual review: no significant changes; revised policy/criteria section to also include generic itraconazole; revised criteria to specify capsule or solution formulation for respective FDA-approved indications; updated drug interaction contraindications per PI; clarified contraindication in patients with CHF for treatment of onychomycosis or non-threatening infections only; references reviewed and updated.	01.30.24	05.24
2Q 2025 annual review: no significant changes; references reviewed and updated. Added step therapy bypass for IL HIM per IL HB 5395.	01.21.25	05.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.