VENTURA COUNTY
HEALTH CARE PLAN

PRIOR AUTHORIZATION POLICY

POLICY: Antifungals – Voriconazole (Oral) Prior Authorization Policy
- Vfend® (voriconazole tablets and oral suspension – Roerig/Pfizer, generic)

REVIEW DATE: 07/16/2025

OVERVIEW

Voriconazole, an azole antifungal, is indicated in patients ≥ 2 years of age for the following uses:[1]
- **Candidemia,** in non-neutropenic patients and other deep tissue *Candida* infections.
- **Esophageal candidiasis.**
- **Invasive aspergillosis.**
- ***Scedosporium apiospermum*** (asexual form of *Pseudallescheria boydii*) and ***Fusarium spp***. (including *Fusarium solani*), in patients intolerant of, or refractory to, other therapy.

The duration of voriconazole therapy is varied.[1] The median duration for invasive aspergillosis is 76 days, but can range to up to 232 days.

Guidelines

The Infectious Diseases Society of America (IDSA) recommends voriconazole as a treatment option for the treatment or prevention of invasive aspergillosis (2016) and for candidemia and candidiasis.[2,3] Use of voriconazole for treatment of infections caused by *Candida* spp and *Aspergillus* spp are also noted in the National Comprehensive Cancer Network (NCCN) guidelines for the prevention and treatment of cancer-related infections (version 1.2025 – June 20,2025).[4] The IDSA guidelines for management of candidiasis note voriconazole has demonstrated effectiveness for candidemia and candidiasis, including mucosal and invasive candidiasis (e.g., *Candida* intravascular infections, including endocarditis and infections of implantable cardiac devices; fluconazole-refractory oropharyngeal candidiasis; *Candida* endophthalmitis).[3] Voriconazole represents an option in the first-line treatment of infections due to *Scedosporium* spp and *Fusarium* spp.[5]

NCCN guidelines also notes voriconazole as a treatment option for the prevention of fungal infections in patients with significant graft-versus-host disease (GVHD) [especially grade 3/4] who are receiving immunosuppressive therapy; treatment should continue until resolution of significant GVHD.[4] Voriconazole is also a treatment option for these groups of patients with neutropenia: patients with myelodysplastic syndrome, patients with acute myeloid leukemia, and patients who are allogeneic hematopoietic cell transplant recipients; treatment should continue until resolution of neutropenia.

The IDSA guidelines for the management of blastomycosis (2008; archived) note voriconazole as an option for the treatment of central nervous system blastomycosis.[6]

The Guidelines for Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with Human Immunodeficiency Virus (HIV) Infections (last updated April 2025) recommend voriconazole as a treatment option for the prophylaxis/treatment of various fungal infections (e.g., candidiasis, histoplasmosis, coccidioidomycosis, and talaromycosis) in patients with HIV.[7]

POLICY STATEMENT
Prior Authorization is recommended for prescription benefit coverage of Vfend tablets and oral suspension and generic voriconazole tablets and oral suspension. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA
Coverage of Vfend/Voriconazole is recommended in those who meet one of the following criteria:

FDA-Approved Indications

1. ***Aspergillus* Infection – Treatment.** Approve for 12 months.

2. ***Candida* (Systemic) Infection – Treatment.** Approve for 3 months.

3. **Esophageal Candidiasis – Treatment.** Approve for 3 months.

4. ***Fusarium* Infection – Treatment.** Approve for 3 months.

5. ***Scedosporium apiospermum* Infection – Treatment.** Approve for 3 months.

Other Uses with Supportive Evidence

6. ***Aspergillus* Infection – Prophylaxis.** Approve for 6 months.

7. **Blastomycosis – Treatment.** Approve for 12 months.

8. ***Candida* Endophthalmitis – Treatment.** Approve for 3 months.

9. **Fungal Infection (Systemic) in a Patient with Cancer and Neutropenia – Prophylaxis.** Approve for 6 months.
   Note: Examples of cancers predisposing neutropenic patients to risk of fungal infections include: myelodysplastic syndrome, acute myeloid leukemia, patients post-allogeneic hematopoietic cell transplant

10. **Fungal Infection (Systemic) in a Patient with Graft-versus-Host Disease - Prophylaxis**. Approve for 6 months.

11. **Fungal Infection (Systemic) in a Patient with Human Immunodeficiency Virus (HIV) – Prophylaxis or Treatment.** Approve for 6 months.

12. **Oropharyngeal Candidiasis (Fluconazole-Refractory) – Treatment.** Approve for 3 months.

13. **Fungal Infection (Systemic) that is Susceptible to Voriconazole – Treatment.** Approve for 3 months.

14. **Patient is Currently Receiving Voriconazole.** Approve for 3 months to complete the course of therapy.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Vfend/voriconazole is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Vfend® tablet and oral suspension [prescribing information]. New York, NY: Roerig/Pfizer; March 2025.
2. Patterson TF, Thompson 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-e60.
3. Pappas PG, Kauffman CA, Andes DR, et al. Clinical practice guidelines for the management of candidiasis: 2016 update by the Infectious Diseases Society of America. *Clin Infect Dis*. 2016;62(4):e1-50.
4. The NCCN Prevention and Treatment of Cancer-Related Infections Clinical Practice Guidelines in Oncology (version 1.2025 – June 20, 2025). ©2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on July 1, 2025
5. Tortorano AM, Richardson M, Roilides E, et al. European Society for Clinical Microbiology and Infectious Diseases (ESCMID) and European Confederation of Medical Mycology (ECMM) joint guidelines on diagnosis and management of hyalohyphomycosis: Fusarium spp., Scedosporium spp. and others. *Clin Microb Infect*. 2014;20(Suppl 3): 37-46.
6. Chapman SW, Dismukes WE, Proia LA, et al. Clinical practice guidelines for the management of blastomycosis: 2008 update by the Infectious Diseases Society of America (Archived). *Clin Infect Dis*. 2008;46:1801-1812.
7. Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: 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/sites/default/files/guidelines/documents/adult-adolescent-oi/guidelines-adult-adolescent-oi.pdf. Last updated April 23, 2025. Accessed on July 1, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Policy name change:** from Voriconazole (Oral) PA to Voriconazole (Oral) PA with Step Therapy. **Fungal Infection (Systemic) in a Patient with Cancer and Neutropenia – Prophylaxis**: This indication was previously worded as "Fungal Infection (Systemic) in a Patient At Risk of Neutropenia – Prophylaxis" and was revised to align with National Comprehensive Cancer Network (NCCN) guidelines. Examples of cancer predisposing neutropenic patients to risk of fungal infections were added as a Note. **Fungal Infection (Systemic) in a Patient with Graft-Versus-Host Disease – Prophylaxis:** This condition of approval was added to the policy.	07/26/2023
Annual Revision	No criteria changes.	07/31/2024
Early Annual Revision	**Policy Statement** was updated to add "When clinically appropriate, the patient is directed to try the generic voriconazole (Step 1) prior to brand Vfend (Step 2). If the patient is requesting brand Vfend and meets the standard *Antifungals – Voriconazole (Oral) PA Policy* criteria but has not met the Step Therapy requirement (i.e. has not tried generic voriconazole), an approval for generic voriconazole will be authorized."	03/05/2025
Early Annual Revision	The policy name was changed to as listed. A Step Therapy component that required a trial of the corresponding generic voriconazole product (tablet or oral suspension) and a formulation difference in the inactive ingredients, which, according to the prescriber, would result in a significant allergy or serious adverse reaction, was removed from the policy. ***Aspergillus* Infection – Treatment:** The duration of approval for this condition was changed to 12 months. Previously, it was 3 months. **Blastomycosis – Treatment:** The duration of approval for this condition was changed to 12 months. Previously, it was 3 months.	07/16/2025