

Antifungals

Goal(s):

- Approve use of antifungals only for OHP-funded diagnoses. Minor fungal infections of skin, such as dermatophytosis and candidiasis are only funded when complicated by an immunocompromised host.
- Allow case-by-case review for members covered under the EPSDT program.

Length of Authorization:

- See criteria

Requires PA:

- Non-preferred drugs

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Table 1: Examples of FUNDED indications (07/08/2025)

ICD-10	Description
B37.1	Candidiasis of the lung
B37.3	Candidiasis of vulva and vagina (vaginitis and cervicitis)
B37.42, B37.49	Candidiasis of other urogenital sites
B37.5-37.6, B37.81-37.84, B37.89	Candidiasis of other specified sites
B37.7	Disseminated Candidiasis
B38.0-B38.4, B38.7, B38.9	Coccidiomycosis various sites
B39.0-39.5, B39.9, G02, I32, I39, J17	Histoplasmosis, subacute meningitis, acute bacterial meningitis
B40.9, B41.0, B41.9, B48.0	Blastomycosis
B42.0-42.9, B43.9, B44.9-45.0, B45.7, B45.9, B46.9, B48.1-48.2, B48.8, B49	Rhinosporidiosis, Sporotrichosis, Chromoblastomycosis, Aspergillosis, Mycosis Mycetomas, Cryptococcosis, Allescheriosis, Zygomycosis, Dematiaceous Fungal Infection, Opportunistic Mycosis, Mycoses Nec and Nos
B44.81	Bronchopulmonary Aspergillus, Allergic
L03.019, L03.029, L03.039, L03.049	Cellulitis and abscess of finger and toe
L30.4	Severe intertrigo (see HERC guideline note 21 for definition of severe inflammatory skin disease)
N73.9-75.1, N76.0-N77.1	Acute inflammatory pelvic disease
P37.5	Neonatal Candida infection

Table 2: Examples of NON-FUNDED indications (07/08/2025)

ICD-10	Description
B36.0	Pityriasis versicolor
B36.2	Tinea blanca
B36.3	Black piedra
B36.8, B36.9	Mycoses, superficial
B37.2	Cutaneous candidiasis
B37.9	Candidiasis, unspecified
L20.0-20.84, L20.89-20.9	Other atopic dermatitis and related conditions
L21.0-21.1, L21.8-21.9,	Erythemasquamous dermatosis
L22	Diaper or napkin rash

L23.0, 23.81, L24.0-24.2, L24.81, L25.0, L25.1-25.5, L25.8-L25.9, L55.1-L55.2, L56.8, L57.8, L57.9, L58.9	Contact dermatitis and other eczema
L26, L30.4, L49.0-L49.9, L51.0, L51.8-L51.9, L52, L53.0-L53.2, L53.8, L53.9, L71.0-L71.1, L71.8, L92.0, L93.0, L93.2, L95.1, L98.2	Erythematous conditions
L43.8, L44.1-44.3, L44.9, L66.1	Lichen Planus
L70.0-70.2, L70.8	Rosacea or acne
R21	Rash and other nonspecific skin eruption

Table 3: Diagnosis funded by OHP if criteria are met (7/08/25)

ICD-10	Description
B35.0	Dermatophytosis of scalp and beard (tinea capitis/ tinea barbae)
B35.1	Tinea unguium (onychomycosis)
B35.2	Dermatophytosis of hand (tinea manuum)
B35.3	Dermatophytosis of foot (tinea pedis)
B35.5	Dermatophytosis of body (tinea corporis / tinea imbricate)
B35.6	Dermatophytosis of groin and perianal area (tinea cruris)
B35.8-B35.9	Deep seated dermatophytosis; dermatophytosis of other specified sites - unspecified site
B36.1	Tinea nigra
B37.83	Candidiasis of mouth

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code	
2. Is the diagnosis funded by OHP? (See examples in Table 1)	Yes: Go to #3	No: Go to #8
3. Is the request for oteseconazole?	Yes: Go to #4	No: Go to #7
4. Does the patient have a diagnosis of recurrent vulvovaginal candidiasis (RVVC) defined as a history of 3 or more episodes of acute vulvovaginal candidiasis (VVC) in the previous 12 months?	Yes: Go to #5	No: Pass to RPh. Deny; medical appropriateness.
5. Has the patient failed to have benefit with, or have contraindications or intolerance to, a course of oral fluconazole for recurrent vulvovaginal candidiasis?	Yes: Go to #6	No: Pass to RPh. Deny; medical appropriateness.
6. Is the patient of reproductive potential?	Yes: Pass to RPh. Deny; medical appropriateness.	No: Approve up to 18 capsules for 12 months

Approval Criteria		
<p>7. Will the prescriber consider a change to a preferred product? Message:</p> <ul style="list-style-type: none"> Preferred products do not require PA. Preferred products are evidence-based reviewed for comparative effectiveness and safety. 	<p>Yes: Inform prescriber of preferred alternatives.</p>	<p>No: Approve for 3 months or course of treatment.</p>
<p>8. Is the prescriber a hematology, oncology or infectious disease specialty prescriber requesting voriconazole or posaconazole?</p>	<p>Yes: Approve for 3 months or course of treatment.</p>	<p>No: Go to #9</p>
<p>9. Is the diagnosis not funded by OHP? (see examples in Table 2).</p>	<p>Yes: If not eligible for EPSDT review: Pass to RPh. Deny; not funded by the OHP</p> <p>If eligible for EPSDT review: Go to #10</p>	<p>No: Go to #10</p>
<p>10. Is the diagnosis funded by OHP if criteria are met? (see examples in Table 3).</p>	<p>Yes: Go to #11</p>	<p>No: Go to #16</p>
<p>11. Is the patient immunocompromised (examples below)?</p> <ul style="list-style-type: none"> Does the patient have a current (not history of) diagnosis of cancer AND is currently undergoing Chemotherapy or Radiation? Document therapy and length of treatment. OR Does the patient have a diagnosis of HIV/AIDS? OR Does the patient have sickle cell anemia? Poor nutrition, elderly or chronically ill? Other conditions as determined and documented by a RPh. 	<p>Yes: Record ICD-10 code. Approve as follows: (immunocompromised patient)</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p style="background-color: black; color: white; margin: 0; padding: 2px;">ORAL & TOPICAL</p> <ul style="list-style-type: none"> Course of treatment. If length of therapy is unknown, approve for 3 months. </div>	<p>No: Go to #12</p>

Approval Criteria

12. Is the patient currently taking an immunosuppressive drug? Document drug.

Pass to RPh for evaluation if drug not in list.

Immunosuppressive drugs include but are not limited to:

azathioprine	leflunomide
basiliximab	mercaptopurine
cyclophosphamide	methotrexate
cyclosporine	mycophenolate
etanercept	rituximab
everolimus	sirolimus
hydroxychloroquine	tacrolimus
infliximab	

Yes: Approve as follows: (immunocompromised patient)

ORAL & TOPICAL

- Course of treatment.
- If length of therapy is unknown, approve for 3 months.

No: Go to #13

13. Is the request for treatment of a foot condition and does the member meet criteria for high-risk foot care?

Antifungals are funded when all of the following criteria are met:

- 1) The patient is at high risk for nail/foot complications due to severe circulatory insufficiency and/or areas of desensitization OR resides in an institutional setting (e.g., skilled nursing/rehabilitation facility, group home, etc.)
AND
- 2) There is clinical evidence of mycosis of the toenail;
AND
- 3) The patient has documented marked limitation of ambulation, pain, and/or secondary bacterial infection resulting from the thickening and dystrophy of the infected toenail plate.

Yes: Approve as follows:

ORAL & TOPICAL

- Course of treatment.
- If length of therapy is unknown, approve for 3 months.

No: If not eligible for EPSDT review: Pass to RPh. Deny; not funded by the OHP

If eligible for EPSDT review: Go to #14

14. Is there documentation that the condition is of sufficient severity that it impacts the patient's health (e.g., quality of life, function, growth, development, ability to participate in school, perform activities of daily living, etc.)?

Yes: Go to #15

No: Pass to RPh. Deny; medical necessity.

Approval Criteria

15. Is the request for a preferred product OR has the patient failed to have benefit with, or have contraindications or intolerance to, at least 2 preferred products?

Message:

Preferred products are evidence-based reviewed for comparative effectiveness and safety by the Oregon Pharmacy & Therapeutics Committee.

Yes: Approve for 12 months.

No: Pass to RPh. Deny; medical appropriateness.

Inform prescriber of covered alternatives in class and process appropriate PA.

16. RPh only: All other indications need to be evaluated to see if it is an OHP-funded diagnosis:

- If funded: may approve for treatment course with PRN renewals. If length of therapy is unknown, approve for 3-month intervals only.
- If not funded:
 - If the member is eligible for EPSDT review, is there documentation that the condition is of sufficient severity that it impacts the patient's health (e.g., quality of life, function, growth, development, ability to participate in school, perform activities of daily living, etc.)?
 - If yes, may approve for treatment course with PRN renewals. If length of therapy is unknown, approve for 3-month intervals only.
 - If No, deny (medical necessity)
 - If the member is not eligible for EPSDT, Deny; not funded by the OHP.
 - Deny non-fungal diagnosis (medical appropriateness)
 - Deny fungal ICD-10 codes that do not appear on the OHP list pending a more specific diagnosis code (not funded by the OHP).
 - Forward any fungal ICD-10 codes not found in the Tables 1, 2, or 3 to the Lead Pharmacist. These codes will be forwarded to DMAP to be added to the Tables for future requests.

P&T Review: 12/25 (KS); 12/23;12/22; 2/22; 11/19; 7/15; 09/10; 2/06; 11/05; 9/05; 5/05
Implemented: 1/1/24; 1/1/23; 4/1/22; 5/1/16; 8/15; 1/1/11; 7/1/06; 11/1/0; 9/1/0