Pharmacy Medical Necessity Guidelines
Topical Antifungal Agents
Effective: 4/1/15

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<th>Clinical Documentation and Prior Authorization Required</th>
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OVERVIEW
FDA-APPROVED INDICATIONS
Topical antifungal agents are indicated for the treatment of tinea corporis (ringworm), tinea cruris (jock itch), and tinea pedis (athlete’s foot) caused by Trichophyton rubrum, Trichophyton mentagrophytes, and Epidermophyton floccosum; tinea (pityriasis) versicolor caused by Pityrosporum orbiculare (also known as Malassezia furfur); cutaneous candidiasis caused by Candida sp.; and seborrheic dermatitis

Topical Antifungal Agents*

Preferred Products

- Ciclopirox Cream, Suspension
- Clotrimazole 1% Cream/Lotion/Solution
- Clotrimazole/Betamethasone 0.05% Cream, Lotion
- Econazole 1% Cream
- Ketoconazole 2% Cream/Shampoo
- Miconazole 2% Cream/Powder (OTC)
- Nystatin Cream/Ointment/Powder
- Terbinafine 1% Cream (OTC)
- Triamcinolone/Nystatin
- Ciclopirox Shampoo/Soln/Susp
- Ciclopirox 0.77% Gel (Loprox)
- Nystatin/Triamcinolone Cream/Ointment
- Oxiconazole 1% Cream (Oxistat)
- Echinaconazole 10% Soln (Jublia)
- Sulconazole 15 Cream/Soln (Ertaczo; Exelderm)
- Tavaborole 5% Soln (Kerydin)

Non-Preferred Products

- Naftifine 2% Cream; 1% Gel (Naftin)
- Nystatin/Triamcinolone Cream/Ointment
- Econazole 1% Foam (Ecoza)
- Luliconazole 1% Cream (Luzu)
- Tavaborole 5% Soln (Kerydin)

PHARMACY COVERAGE GUIDELINES
Tufts Health Plan – Network Health may authorize coverage of topical antifungal agents for members when criteria for a particular regimen are met and limitations do not apply:
The member had an insufficient response to therapy with at least two preferred antifungal agents, or with individual agents if the request is for a combination product.

If the request is for treatment of onychomycosis of the nail,
- The provider documented the need to avoid systemic antifungal therapies.
- The member had an insufficient response to a full course of therapy with ciclopirox 8% topical solution.

Upon renewal,
- The member has had an office visit and has been re-assessed for this condition within the past year, and continued therapy with this medication is medically necessary.

LIMITATIONS
Approval will be limited to a one year duration.

CODES
None

REFERENCES

APPROVAL HISTORY
- 12/9/14: Reviewed by the Pharmacy and Therapeutics Committee. Incorporated Jublia, Kerydin Luzu; modified approval to one year with change in renewal criteria; modified criteria for onychomycosis with preferred therapy with ciclopirox; updated table with preferred therapies.

BACKGROUND, PRODUCT, AND DISCLAIMER INFORMATION
Pharmacy Medical Necessity Guidelines have been developed for determining coverage for Tufts Health Plan – Network Health benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with the applicable Member Handbook and in coordination with the member’s physician(s). Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan – Network Health service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan – Network Health reviews Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medical Necessity Guidelines apply to all fully insured Tufts Health Plan – Network Health offerings unless otherwise noted in this policy or the applicable Member Handbook. Check the applicable product formulary in the Pharmacy section of our website to determine if the drug requires you to get prior authorization.

For Tufts Health Unify (Medicare-Medicaid One Care for people ages 21 – 64), please refer to Tufts Health Unify Prior Authorization Medical Necessity Guidelines.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines, when applicable, and adherence to plan policies and procedures and claims editing logic.