



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Voriconazole

Page: 1 of 4

Effective Date: 5/28/2025

Last Review Date: 5/2025

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|-------------|--|--|---|
| Applies to: | <input checked="" type="checkbox"/> Illinois | <input type="checkbox"/> Florida | <input checked="" type="checkbox"/> New Jersey |
| | <input checked="" type="checkbox"/> Maryland | <input checked="" type="checkbox"/> Florida Kids | <input checked="" type="checkbox"/> Pennsylvania Kids |
| | <input type="checkbox"/> Michigan | <input type="checkbox"/> 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^{2,3,9,11}
- Fungal Peritoneal Dialysis-Associated Peritonitis^{3,6}
- Invasive Aspergillosis, Prophylaxis, High-Risk Patients^{3,9}
- Mycosis, Due to *Scedosporium prolificans*³
- Oropharyngeal Candidiasis^{2,3,8}
- Pulmonary Aspergillosis, Chronic^{3,9}



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- Talaromycosis^{3,5,7}

Applicable Drug List:

Preferred Agent:

Voriconazole 50mg and 200mg tablets

Non-Preferred Agent:

Voriconazole Suspension

Policy/Guideline:

Coverage Criteria

Aspergillosis, Febrile Neutropenia, Fungal Peritonitis, Mycosis, Serious Fungal Infection

Authorization may be granted for the requested drug when ALL of the following criteria are met:

- The requested drug is being prescribed for ANY of the following:
 - Treatment of invasive aspergillosis (including invasive pulmonary aspergillosis).
 - Serious fungal infection caused by *Scedosporium apiospermum* and *Fusarium* species.
 - Prophylaxis of invasive aspergillosis in a high-risk patient.
 - Chronic pulmonary aspergillosis.
 - Empiric antifungal therapy for febrile neutropenia in a high-risk patient.
 - Mycosis due to *Scedosporium prolificans*.
 - Fungal Peritoneal Dialysis-Associated Peritonitis.
- The patient will use the requested drug orally or intravenously.
- If the request is for voriconazole powder for oral suspension, the patient meets ONE of the following: has difficulty swallowing solid oral dosage forms (e.g., tablets), requires a dose that cannot be obtained using the commercially available tablets.

Candida Infection, Talaromycosis

Authorization may be granted for the requested drug when ALL of the following criteria are met:

- The requested drug is being prescribed for ANY of the following:
 - Candidemia in a non-neutropenic patient.
 - Disseminated Candida infection in the skin.
 - Candida infection in the abdomen, kidney, bladder wall, or wounds.



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- Esophageal candidiasis.
 - Oropharyngeal candidiasis.
 - Talaromycosis.
- The patient meets ONE of the following criteria:
 - The patient has experienced an inadequate treatment response to an alternative antifungal therapy.
 - The patient has experienced an intolerance to an alternative antifungal therapy.
 - The patient has a contraindication that would prohibit a trial of an alternative antifungal therapy.
- The patient will use the requested drug orally or intravenously.
- If the request is for voriconazole powder for oral suspension, the patient meets ONE of the following: has difficulty swallowing solid oral dosage forms (e.g., tablets), requires a dose that cannot be obtained using the commercially available tablets.

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 6 months

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

References:

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4. Centers for Disease Control and Prevention. Aspergillosis Basics. Available at: <https://www.cdc.gov/aspergillosis/about/index.html>. Accessed December 11, 2024.
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10. 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.
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