

# Initial Prior Authorization

## Vfend

### Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Vfend	voriconazole

### Indications

#### FDA-approved Indications

##### Invasive Aspergillosis

Vfend 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

Vfend 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

Vfend is indicated in adults and pediatric patients (2 years of age and older) for the treatment of esophageal candidiasis (EC).

## Scedosporiosis and Fusariosis

Vfend 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.

## Usage

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<sup>2,3,9,11</sup>
- Fungal Peritoneal Dialysis-Associated Peritonitis<sup>3,6</sup>
- Invasive Aspergillosis, Prophylaxis, High-Risk Patients<sup>3,9</sup>
- Mycosis, Due to *Scedosporium prolificans*<sup>3</sup>
- Oropharyngeal Candidiasis<sup>2,3,8</sup>
- Pulmonary Aspergillosis, Chronic<sup>3,9</sup>
- Talaromycosis<sup>3,5,7</sup>

## Coverage Criteria

### Aspergillosis, Candida Infection, Febrile Neutropenia, Fungal Peritonitis, Mycosis, Serious Fungal 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:
  - Treatment of invasive aspergillosis (including invasive pulmonary aspergillosis).
  - Candidemia in a non-neutropenic patient.
  - Disseminated Candida infection in the skin.
  - Candida infection in the abdomen, kidney, bladder wall, or wounds.
  - Esophageal candidiasis.
  - 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.
  - Oropharyngeal candidiasis.
  - Mycosis due to *Scedosporium prolificans*.
  - Fungal Peritoneal Dialysis-Associated Peritonitis.

- Talaromycosis.
- The patient will use the requested drug orally or intravenously.

## Duration of Approval

- 2812-A: DOA: 6 months

## References

1. Vfend [package insert]. New York, New York: Roerig, Division of Pfizer Inc.; August 2024.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2024. <https://online.lexi.com>. Accessed December 2, 2024.
3. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: 12/2/2024).
4. Centers for Disease Control and Prevention. Aspergillosis Basics. Available at: <https://www.cdc.gov/aspergillosis/about/index.html>. Accessed December 11, 2024.
5. Centers for Disease Control and Prevention. Talaromycosis (Penicilliosis) Basics. Available at: <https://www.cdc.gov/talaromycosis/about/index.html>. Accessed December 11, 2024.
6. Li, Philip Kam-Tao et al. ISPD peritonitis guideline recommendations: 2022 update on prevention and treatment. Peritoneal dialysis international : journal of the International Society for Peritoneal Dialysis vol. 42,2 (2022): 110-153
7. Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. National Institutes of Health, Centers for Disease Control and Prevention, HIV Medicine Association, and Infectious Diseases Society of America. Available at <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection>. Accessed December 3, 2024.
8. Pappas PG, Kauffman CA, Andes DR, et al. Clinical Practice Guideline for the Management of Candidiasis: 2016 Update by the Infectious Diseases Society of America. Clin Infect Dis 2016;62(4):e1-50.
9. Patterson TF, Thompson III 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):e1-60.
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.
11. Freifeld AG, Bow EJ, Sepkowitz KA et al. Clinical Practice Guideline for the Use of Antimicrobial Agents in Neutropenic Patients with Cancer: 2010 Update by the Infectious Diseases Society of America. Clin Infect Dis 2011;52(4):e56-93.

# Document History

Written by: UM Development (RP)

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Reviewed: Medical Affairs (GAD) 12/2018, (CHART) 01/02/20, (CHART) 12/31/20, (CHART) 12/30/2021, 12/29/2022, 12/21/2023, 12/19/2024

External Review: 02/2019 (FYI), 06/2019, 04/2020, 04/2021, 04/2022, 04/2023, 04/2024, 04/2025

## **CRITERIA FOR APPROVAL**

- |   |   |           |
|---|---|-----------|
| 1 | Is the requested drug being prescribed for ANY of the following: A) treatment of invasive aspergillosis (including invasive pulmonary aspergillosis), B) candidemia in a non-neutropenic patient, C) disseminated Candida infection in the skin, D) Candida infection in the abdomen, kidney, bladder wall, or wounds, E) esophageal candidiasis, F) serious fungal infection caused by <i>Scedosporium apiospermum</i> or <i>Fusarium</i> species, G) prophylaxis of invasive aspergillosis in a high-risk patient, H) chronic pulmonary aspergillosis, I) empiric antifungal therapy for febrile neutropenia in a high-risk patient, J) oropharyngeal candidiasis, K) mycosis due to <i>Scedosporium prolificans</i> , L) fungal peritoneal dialysis-associated peritonitis, M) talaromycosis?<br>[If Yes, then go to 2. If No, then no further questions.] | Yes    No |
| 2 | Will the patient be using the requested drug orally or intravenously?<br>[No further questions]   | Yes    No |

Mapping Instructions			
	Yes	No	DENIAL REASONS
1.	Go to 2	Deny	Your plan only covers this drug when it is used for certain health conditions. Covered use is for specific types of fungal infections. Your plan does not cover this drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.

			[Short Description: Diagnosis]
<b>2.</b>	Approve, 6 Months	Deny	<p>Your plan only covers this drug when you are taking it by mouth or as an injection. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Route of administration]</p>