STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

Antifungal Agents

Prior Authorization Request Form

A maximum of two (2) fluconazole tablets may be reimbursed within a thirty (30) day period without prior authorization. Prior approval for larger quantities of fluconazole and other oral antifungal agents must meet the criteria stated below.

Prior authorization requests for Antifungal Agents will be approved if the following criteria are met:

1. Diagnosis of or at risk for a systemic fungal infection; **OR**
2. Diagnosis of onychomycosis, with a KOH test or culture, in patients with diabetes, HIV, cancer, previous organ transplant or are otherwise immunocompromised. **OR**
3. Diagnoses of other fungal infections requiring long-term treatment and have other co-morbid conditions such as diabetes, HIV, cancer, previous organ transplant or are otherwise immunocompromised

Review and Approved
DUR Board 08/2010