



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



Office of Pharmacy Service  
Prior Authorization Criteria

Ketoconazole® (oral)  
[Prior Authorization Request Form](#)

**Prior authorization requests for Ketoconazole will be approved if the following criteria are met:**

- 1) Diagnosis of one (1) of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis; **AND**
- 2) Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc; **AND**
- 3) Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ration (INR) before starting treatment; **AND**
- 4) Weekly monitoring of serum ALT for the duration of the treatment; **AND**
- 5) Ketoconazole will **not** be approved for treatment for fungal infections of the skin and nails.

*US Food and Drug Administration  
July 26, 2013*

*Review and Approved  
DUR Board 11/20/2013*