Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines:
Oral Antifungal Agents

Effective: September 15, 2026

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

Cresemba (isavuconazonium) capsule is an azole antifungal indicated for adult and pediatric patients 6 years of age and older who weigh 16 kilograms (kg) and greater for the treatment of invasive aspergillosis and invasive mucormycosis.

Noxafil (posaconazole) [delayed-release tablets, and oral suspension] is an azole antifungal agent indicated for prophylaxis of invasive *Aspergillus* and *Candida* infections in patients who are at high risk of developing these infections due to being severely immunocompromised, such as HSCT recipients with GVHD or those with hematologic malignancies with prolonged neutropenia from chemotherapy. Posaconazole DR tablet is also indicated for the treatment of invasive aspergillosis in adults and pediatric patients 2 years of age and older who weigh greater than 40 kg.

Noxafil (posaconazole) oral suspension is also indicated for the treatment of oropharyngeal candidiasis, including oropharyngeal candidiasis refractory to itraconazole and/or fluconazole.

Clinical Guideline Coverage Criteria

Cresemba (isavuconazonium)

The plan may authorize coverage of **Cresemba (isavuconazonium) capsules** when the following criteria are met:

1. The patient was started on Cresemba (isavuconazonium) in an inpatient setting

OR

2. The patient has a diagnosis of invasive mucormycosis **AND** patient had an inadequate response, intolerance, or contraindication to posaconazole

OR

3. The patient has a diagnosis of invasive aspergillosis **AND** patient had an inadequate response, intolerance, or contraindication to voriconazole

Posaconazole

The plan may authorize coverage of **posaconazole DR tablets, or oral suspension (Noxafil)** when the following criteria are met:

1. The patient was started on posaconazole in an inpatient setting

OR

2. Documented diagnosis of Zygomycosis (mucormycosis)

OR

3. The patient has a diagnosis of invasive aspergillosis

OR

4. Posaconazole is prescribed for prevention of invasive aspergillus and candida fungal infections **AND** documented diagnosis of hematologic malignancy with neutropenia, or graft-versus-host disease, or the patient has undergone a hematopoietic stem cell transplant

OR

5. Documented diagnosis of esophageal candidiasis **AND** documented failure of or clinical inappropriateness of therapy with at least TWO of the following: oral fluconazole, itraconazole, and voriconazole

OR

6. Documented diagnosis of oropharyngeal candidiasis **AND** documented failure of or clinical inappropriateness of therapy with all of the following: oral fluconazole **AND** itraconazole

Limitations

1. For a non-formulary medication request, please refer to the Pharmacy Medical Necessity Guidelines for Formulary Exceptions and submit a formulary exception request to the plan as indicated.

Codes

None

References

1. Cresemba (isavuconazonium) [prescribing information]. Northbrook, IL: Astellas Pharma US, Inc.; April 2025.
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3. Krob AH, Fleischer AB Jr, D'Agostino R Jr, Feldman SR. Terbinafine is more effective than itraconazole in treating toenail onychomycosis: results from a meta-analysis of randomized controlled trials. *J Cutan Med Surg*. 2003; 7:306–311.
4. Mishra M, Panda P, Tripathy S et al. An open randomized comparative study of oral itraconazole pulse and terbinafine pulse in the treatment of onychomycosis. *Indian J Dermatol Venereol Leprol* 2005; 71:262-6
5. Noxafil (posaconazole) [prescribing information]. Whitehouse Station, NJ: Merck & Co Inc; February 2026.
6. Perfect JR, Dismukes WE, Dromer F, et al. Clinical practice guidelines for the management of cryptococcal disease: 2010 update by the Infectious Diseases Society of America. Clin Infect Dis. 2010;50(3):291-322.
7. Vfend (voriconazole) [prescribing information]. New York, NY: Pfizer; February 2026.
8. Cox GM. Mucormycosis (zygomycosis). www.uptodate.com. Accessed 21 August 2025.
9. Patterson TF. Treatment and prevention of invasive aspergillosis. www.uptodate.com. Accessed 21 August 2025.
10. Patterson TF, Thompson GR 3rd, 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 Aug 15;63(4):e1-e60. doi: 10.1093/cid/ciw326. Epub 2016 Jun 29. PMID: 27365388; PMCID: PMC4967602.
11. Cornely OA, Alastruey-Izquierdo A, Arenz D, et al; Mucormycosis ECMM MSG Global Guideline Writing Group. Global guideline for the diagnosis and management of mucormycosis: an initiative of the European Confederation of Medical Mycology in cooperation with the Mycoses Study Group Education and Research Consortium. Lancet Infect Dis. 2019 Dec;19(12):e405-e421. doi: 10.1016/S1473-3099(19)30312-3. Epub 2019 Nov 5. PMID: 31699664; PMCID: PMC8559573.

Approval And Revision History

September 13, 2022: Reviewed by the Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- September 12, 2023: Effective December 1, 2023, updated criteria for Cresemba in invasive mucormycosis to include a trial with Posaconazole. Updated Posaconazole criteria to not require request is for oral suspension when prescribed for the treatment of oropharyngeal or esophageal candidiasis.
- September 10, 2024: Administrative update to overview to include Cresemba's expanded indication in pediatric patients 6 years of age and older who weigh 16 kilograms (kg) and greater for the treatment of invasive aspergillosis and invasive mucormycosis.
- September 9, 2025: No changes.
- September 15, 2026: Administrative update to overview with posaconazole DR tablet's expanded indication for the treatment of invasive aspergillosis in adults and pediatric patients 2 years of age and older who weigh greater than 40 kg. Administrative update to remove Carelink from Medical Necessity Guideline template.

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. 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 service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

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.