

# PRIOR AUTHORIZATION CRITERIA

**BRAND NAME**  
(generic)

**SPORANOX ORAL SOLUTION**  
(itraconazole)

**Status: CVS Caremark Criteria**  
**Type: Initial Prior Authorization**

## POLICY

### FDA-APPROVED INDICATIONS

Sporanox (itraconazole) Oral Solution is indicated for the treatment of oropharyngeal and esophageal candidiasis.

### COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has a diagnosis of oropharyngeal candidiasis or esophageal candidiasis  
**AND**
- The patient has experienced an inadequate treatment response to fluconazole  
**OR**
- The patient has experienced an intolerance to fluconazole  
**OR**
- The patient has a contraindication that would prohibit a trial of fluconazole

### REFERENCES

1. SporanoX Oral Solution [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc.; April 2019.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: UpToDate, Inc. 2021. Accessed January 12, 2021.
3. Micromedex (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: <https://www.micromedexsolutions.com>. Accessed January 12, 2021.
4. Pappas P, Kauffman C, Andes D, et al. Clinical Practice Guidelines for the Management of Candidiasis: 2016 Update by the Infectious Diseases Society of America. *Clinical Infectious Diseases*. 2016;62:1-50.