

Clinical Policy Title:	Azole Antifungals
Policy Number:	RxA.915
Drug(s) Applied:	Cresemba, posaconazole tablets
Original Policy Date:	6/30/2025
Last Review Date:	12/11/2025
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Aspergillosis (Cresemba, posaconazole) (must meet all):

1. Diagnosis of invasive aspergillosis;
2. Trial and failure of voriconazole, unless contraindicated or clinically significant adverse events are experienced;
3. If the request is for Cresemba, trial and failure of posaconazole, unless contraindicated or clinically significant adverse events are experienced.

Approval Duration

All Lines of Business (except Medicare): 3 months

B. Aspergillosis Prophylaxis (posaconazole) (must meet all):

1. Prescribed for the prophylaxis of invasive aspergillosis.

Approval Duration

All Lines of Business (except Medicare): 12 months

C. Invasive Candidiasis Prophylaxis (posaconazole) (must meet all):

1. Prescribed for the prophylaxis of invasive candidiasis.

Approval Duration

All Lines of Business (except Medicare): 12 months

D. Mucormycosis (Cresemba, posaconazole) (must meet all):

1. Diagnosis of mucormycosis;
2. If the request is for Cresemba, trial and failure of posaconazole, unless contraindicated or clinically significant adverse events are experienced.

Approval Duration

All Lines of Business (except Medicare): 12 months

E. Esophageal Candidiasis (must meet all):

1. Diagnosis of esophageal candidiasis;
2. Trial and failure of both of the following, unless contraindicated or clinically significant adverse events are experienced (a and b):
 - a. Fluconazole;
 - b. Voriconazole;

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

3. If the request is for Cresemba, trial and failure of itraconazole solution.

Approval Duration

All Lines of Business (except Medicare): 1 month

F.

II. Continued Therapy Approval

A. All Indications (must meet all):

1. Re-authorization is not permitted. Members must meet the initial approval criteria.

References

1. 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; 63:e1.
2. 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:e1.
3. Kauffman CA, Malani AN. Zygomycosis: an emerging fungal infection with new options for management. Curr Infect Dis Rep 2007; 9:435.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	6/30/2025	6/30/2025
Policy reviewed	12/11/2025	12/11/2025