JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Pharmacy Public** **Pharmacy Management Drug Policies**	*Policy Number*	MEDS030
		Effective Date	02/01/2008
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	Subject **Vfend**	*Revision Date*	01/19/2022
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This document applies to the following Participating Organizations:

Priority Partners

Keywords: Vfend

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I. POLICY

A. Vfend (voriconazole) will require prior authorization to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.
   1. PPMCO members are subject to the Priority Partners formulary, available at www.ppmco.org.
   2. USFHP members are subject to prior authorization criteria, step-edits and days-supply limits outlined in the Tricare Policy Manual. Tricare Policy supersedes JHHC Medical/Pharmacy Policies. Tricare limits may be accessed at: http://pec.ha.osd.mil/formulary_search.php?submenuheader=1

II. POLICY CRITERIA

A. Vfend may be approved for patients meeting the following:
   1. Patient is 2 years of age or older
   2. Documentation that Vfend will be used for one of the following:
      a. Primary treatment of pulmonary aspergillus
      b. Primary treatment of amphotericin B and fluconazole resistant fungal infections (including Fusarium spp. and Scedosporium apiospermum - asexual form of Pseudoallescheria boydii)
      c. Treatment of invasive fungal infections (candidemia,deep tissue candida infections, etc.) that is refractory to other antifungal therapy
      d. Treatment of esophageal candidiasis that is refractory to flucanzole therapy
      e. Empirical therapy of neutropenic fever in a patient receiving concomitant nephrotoxins (cyclosporin, tacrolimus).
      f. Prophylaxis in a high-risk patient who is undergoing mini MUD transplants, mini allogeneic BMTs, or allogeneic BMTs, or who has severe graft versus host disease (GVHD)

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Coverage approval may be for 12 months

IV. EXCLUSIONS/PRECAUTIONS

A. Vfend will not be approved for the following:
   1. Patients receiving any of the following contraindicated medications:
      a. pimozide (Orap)

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b. quinidine
c. ivabradine (Corlanor)
d. sirolimus (Rapamune)
e. rifampin
f. carbamazepine
g. long-acting barbiturates (Phenobarbital)
h. St. John's Wort
i. efavirenz doses of 400 mg every 24 hours or higher
j. high-dose ritonavir (400 mg every 12 hours)
k. rifabutin
l. ergot alkaloids (ergotamine and dihydroergotamine/DHE-45)
m. naloxegol (Movantik)
n. tolvaptan (Samsca, Jynarque)
o. venetoclax (Venclexta)
p. lurasidone (Latuda)

2. Any indications or uses that are not FDA-approved, or guideline-supported

B. The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

V. REFERENCES

1. Vfend [prescribing information]. New York, NY: Roerig, Division of Pfizer Inc; October 2021.
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3. Bagg J, Sweeney PM, Voriconazole susceptibility of yeasts isolated from the mouths of patients with advanced cancer. J Med Microbiol 54 (2005), 959-964; DOI: 10.1099/jmm.0.45720-0
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VI. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
07/27/2017	Updated Exclusion section regarding physician changes
01/19/2022	Updated exclusion and clinical criteria sections

Review/Revision Date: 1/14/2009, 07/27/2017, 01/19/2022

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