



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



**Office of Pharmacy Service
Prior Authorization Criteria**

**CRESEMBA®
(isavuconazonium sulfate)
Effective 4/1/2016**

Prior Authorization Request Form

CRESEMBA is an azole antifungal indicated for use in the treatment of invasive aspergillosis and invasive mucormycosis.

Criteria for Approval

- 1) Diagnosis of invasive aspergillosis OR invasive mucormycosis; **AND**
- 2) Patient is ≥ 18 years of age; **AND**
- 3) ONE of the two:
 - a. Patient has a documented side-effect, allergy, contraindication to, or is intolerant of or failed voriconazole if the diagnosis is aspergillosis or Noxafil® (posaconazole) if the diagnosis is mucormycosis; **OR**
 - b. Patient is completing a course of therapy with the requested medication that was initiated in the hospital.

References

- 1) Cresemba package insert revised 6/2015
- 2) Lexi-Comp Clinical Application 02/17/2016
- 3) Treatment of Aspergillosis: Clinical Practice Guidelines of the Infectious Diseases Society of America (http://www.idsociety.org/uploadedFiles/IDSA/Guidelines-Patient_Care/PDF_Library/Aspergillosis.pdf)
- 4) <http://www.uptodate.com/contents/pharmacology-of-azoles>
- 5) <http://www.uptodate.com/contents/mucormycosis-zygomycosis?source=machineLearning&search=mucormycosis&selectedTitle=1%7E68§ionRank=1&anchor=H18#H18>
- 6) <http://www.uptodate.com/contents/treatment-and-prevention-of-invasive-aspergillosis?source=machineLearning&search=invasive+aspergillitis&selectedTitle=1%7E150§ionRank=2&anchor=H5#H5>