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

Office of Pharmacy Service
Prior Authorization Criteria

Ketoconazole® (oral)

Prior Authorization Request Form

Prior authorization requests for Ketoconazole will be approved if the following criteria are met:

1) Diagnosis of one (1) of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis; **AND**
2) Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc; **AND**
3) Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ration (INR) before starting treatment; **AND**
4) Weekly monitoring of serum ALT for the duration of the treatment; **AND**
5) Ketaconazole will **not** be approved for treatment for fungal infections of the skin and nails.

US Food and Drug Administration
July 26, 2013

Review and Approved
DUR Board 11/20/2013