

# Cigna National Preferred Formulary Coverage Policy



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Coverage Policy Number ..... NPF145

## Drug Quantity Management – Per Rx Fluconazole Tablets (Diflucan®, Generics) Dispensing Limit

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### Related Coverage Resources

#### INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

### NPF Coverage Policy

**Cigna covers quantities as medically necessary when the following criteria are met:**

#### Diflucan 150 mg tablet (generic)

Maximum quantity per RX = 2 tablets

The manufacturer recommended dosing for treatment of vaginal candidiasis is one 150-mg tablet, as a single dose. Hence, two tablets should be sufficient for two episodes of vaginal candidiasis. If additional medication is needed, the participant will need to pay additional copayments. For longer duration of therapy (several days in a row), the participant could use other strengths of Diflucan (50 mg, 100 mg, or 200 mg) or other formulary or OTC vaginal antifungals. For recurrent vulvovaginal candidiasis, use of 150 mg of fluconazole weekly for 6 months was found to statistically significantly reduce the rate of recurrence compared with placebo. Also, the Centers for Disease Control and Prevention guidelines for sexually transmitted diseases recommended that for maintenance regimens for recurrent vulvovaginal candidiasis, one option is fluconazole dosed 100 mg to 200 mg once weekly for 6 months. Some specialists recommend a longer duration of initial therapy (e.g., 7–14 days of topical therapy or a 100-mg, 150-mg, or 200-mg oral dose of fluconazole every third day for a total of 3 doses [day 1, 4, and 7]) to attempt mycologic remission before initiating a maintenance antifungal regimen. Diflucan 150 mg once

weekly has been used (but is not FDA approved) to treat various tinea infections (e.g., tinea pedis, tinea cruris, tinea corporis, cutaneous candidiasis). Exceptions can be made for these conditions if necessary. For other indications, individuals should use the 50 mg, 100 mg, or 200 mg tablets.

### Criteria

All approvals are provided for 12 months in duration unless otherwise noted below.

1. Vaginal candidiasis or vulvovaginal candidiasis (non-recurrent):

No override recommended.

2. Treatment of the following:

- a. tinea pedis, tinea cruris, tinea corporis, tinea manuum, tinea faciei
- b. cutaneous candidiasis
- c. maintenance therapy for recurrent vaginal/vulvovaginal candidiasis

Approve 5 tablets per dispensing (1 tablet weekly).

3. Treatment of recurrent vaginal/vulvovaginal candidiasis before initiating maintenance therapy:

Approve a one-time override for a quantity of 3 tablets.

### Conditions Not Covered

Any other exception is considered not medically necessary, including the following:

1. pityriasis (tinea) versicolor
2. tinea capitis
3. tinea barbea
4. onychomycosis
5. coccidioidomycosis
6. cryptococcal meningitis
7. candida urinary tract infections
8. histoplasmosis
9. oropharyngeal or esophageal candidiasis
10. immunocompromised individuals (e.g., bone marrow transplant recipients, cancer chemotherapy and/or radiation therapy individuals)

## References

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7. Wheat LJ, Freifeld AG, Kleiman MB, et al. Clinical Practice Guidelines for the Management of Patients with Histoplasmosis: 2007 Update by the Infectious Diseases Society of America. *Clin Infect Dis*. 2007; 45:807-825. Available at: <https://academic.oup.com/cid/article/45/7/807/541502> Accessed April 09, 2020.
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## Last Revision Details

Annual Revision	Reviewed by Clinical Specialists. No change to criteria.	04/09/2020
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