

New Hampshire Medicaid Fee-for-Service Program Second-Line Antifungal Criteria

Approval Date: January 22, 2024

Medications

Generic Name (Brand Name)	Dosage Form	Indication
luliconazole (Luzu®)	1% topical cream	Treatment of interdigital tinea pedis, tinea cruris, and tinea corporis caused by <i>Trichophyton rubrum</i> or <i>Epidermophyton floccosum</i> in patients \geq 2 years old for tinea corporis and patients \geq 12 years old for tinea cruris and tinea pedis
oxiconazole (Oxistat®)	1% cream/lotion	Treatment of tinea pedis (can be used for both interdigital and plantar), tinea cruris, tinea corporis, and tinea versicolor (cream only) for patients \geq 12 years old
naftifine (Naftin®)	1% cream/gel	Treatment of tinea pedis, tinea cruris, and tinea corporis caused by the organisms <i>Trichophyton rubrum</i> , <i>Trichophyton mentagrophytes</i> , <i>Trichophyton tonsurans</i> , or <i>Epidermophyton floccosum</i>

Criteria for Approval

1. The patient has had an adequate trial and failure (at least 2 weeks within the last 60 days) of topical ciclopirox, clotrimazole, econazole, ketoconazole, miconazole, nystatin, terbinafine, or tolnaftate; **OR**
2. There is a documented intolerance to all first-line topical treatments.

Approval period: 3 months

Criteria for Denial

Failure to meet criteria for approval.

Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	06/02/2022
Commissioner Designee	Approval	07/12/2022
DUR Board	Review	12/08/2023
Commissioner Designee	Approval	01/22/2024