

Posaconazole Criteria

Revised: 10/01/2026

POSACONAZOLE

Length of Authorization: Initial:

Oropharyngeal candidiasis: 1 month

All other indications: 6 months

Renewal:

Oropharyngeal candidiasis: 1 month

All other indications: 6 months

CRITERIA TO APPROVE

Prophylaxis of Invasive Aspergillus or Candida Infection

- The patient is 2 years of age or older
- The patient is severely immunocompromised due to one of the following:
 - Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD); **OR**
 - Hematologic malignancy with prolonged neutropenia secondary to chemotherapy; **OR**
 - Other high-risk immunocompromised conditions supported by current clinical guidelines; **AND**
- The medication is prescribed by or in consultation with an infectious disease, oncology, hematology, or transplant specialist.

Treatment of Invasive Aspergillosis

- The patient is 2 years of age or older
- The patient received a diagnosis of invasive aspergillosis; **AND**
- The medication is prescribed by or in consultation with an infectious disease specialist

Oropharyngeal Candidiasis (Suspension Only)

- The patient is 13 years of age or older; **AND**
- The patient received a diagnosis of oropharyngeal candidiasis; **AND**
- Trial and failure of 2 preferred oral antifungal agents (e.g., nystatin, clotrimazole, fluconazole)

RENEWAL CRITERIA

All the following:

- The patient met initial review requirements; **AND**
- The patient has an overall clinical improvement in response to therapy; **AND**
- The patient has not experienced any treatment-restricting adverse effects.

REVISION HISTORY

Date	Issues/Updates
10/01/2026	Initial draft creation