New Hampshire Medicaid Fee-for-Service Program

Second-Line Antifungal Criteria

Approval Date: July 12, 2022

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 *Trichophyton rubrum* or *Epidermophyton floccosum* in patients ≥ 2 years old for tinea corporis and patients ≥ 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 ≥ 12 years old
naftifine (Naftin®)	1% cream/gel	Treatment of tinea pedis, tinea cruris, and tinea corporis caused by the organisms *Trichophyton rubrum*, *Trichophyton mentagrophytes*, *Trichophyton tonsurans*, or *Epidermophyton floccosum*

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

Reviewed by	Reason for Review	Date Approved
Commissioner Designee	Approval	07/12/2022