



## Office of Pharmacy Service Prior Authorization Criteria

### Ketoconazole (Oral)

**Prior authorization requests for ketoconazole will be approved if each of the following criteria are met:**

1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis
2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc
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
4. Weekly monitoring of serum ALT for the duration of the treatment
5. Ketoconazole will **not** be approved for treatment for fungal infections of the skin and nails

US Food and Drug Administration  
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