Mass General Brigham
Health Plan

Antifungal Topical Agents
Ecoza (econazole),
Extina (ketoconazole),
Loprox (ciclopirox), Lotrisone (clotrimazole/betamethasone),
Mentax (butenafine),
Vusion (miconazole/zinc oxide/white petrolatum)
Xolegel (ketoconazole)
Effective 01/01/2026

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

Overview
Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

Initial Step-Therapy Requirements:
First-Line: Medications listed on first-line are covered without prior-authorization.
Second-Line: Second-line medications will pay if the member has filled for at least a 7 day supply of a generic topical antifungal agent within the past 120 days.

Coverage Guidelines

FIRST-LINE	SECOND-LINE
Generic topical antifungal agent	Ecoza (econazole) Extina (ketoconazole) Loprox (ciclopirox) Lotrisone (clotrimazole/betamethasone) Mentax (butenafine) Vusion (miconazole/zinc oxide/white petrolatum) Xolegel (ketoconazole)

Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted when the following criteria is met:

1. The requested drug will not be used in a footbath.
2. Member experienced an inadequate treatment response to a generic topical antifungal agent intolerance to a generic topical antifungal agent, or has a contraindication that would prohibit a trial of a generic topical antifungal agent.

Limitations

1. Initial approvals will be granted for 3 months.
2. If the member has filled a prescription for at least a 7 day supply of a generic topical antifungal agent within the past 120 days under a prescription benefit, then the requested drug will be paid under that prescription benefit. If the member does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

References

1. Ecoza [package insert]. Mahwah, NJ: Glenmark Therapeutics Inc., USA; October 2020.
2. Extina [package insert]. Morgantown, WV: Mylan Pharmaceuticals Inc.; August 2018.
3. Loprox Cream [package insert]. Fairfield, NJ: Medimetriks Pharmaceuticals; January 2016.
4. Loprox Shampoo [package insert]. Bridgewater, NJ: Bausch Health US, LLC; May 2019.
5. Loprox Suspension (Lotion) [package insert]. Fairfield, NJ: Medimetriks Pharmaceuticals; March 2016.
6. Lotrisone [package insert]. Whitehouse Station, NJ: Merck & Co., Inc. June 2019.
7. Mentax [package insert]. Morgantown, WV: Mylan Pharmaceutical Inc.; June 2018.
8. Rotta I, Ziegelmann PK, Otuki MF, Riveros BS, Bernardo NL, Correr CJ. Efficacy of topical antifungals in the treatment of dermatophytosis: a mixed-treatment meta-analysis involving 14 treatments. JAMA Dermatol. 2013;149(3):341-9.
9. Vusion [package insert]. Morgantown, WV: Mylan Pharmaceuticals Inc.; August 2018.
10. Xolegel [package insert]. Exton, PA: Aqua Pharmaceuticals.; December 2019.

Review History

12/13/2023: Reviewed at Dec P&T, switched from SGM to Custom. Effective 1/1/2024
10/08/2025 – Reviewed and updated at September P&T. Removed sulconazole, luliconazole, naftifine, oxiconazole and sertaconazole from the policy, as these agents are moving to nonformulary status. Effective 1/1/2026.