LOUISIANA BLUE

Tolsura® (itraconazole)

Policy # 00944
Original Effective Date: 01/01/2026
Current Effective Date: 01/01/2026

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider Tolsura®‡ (itraconazole) to be **eligible for coverage**** when the patient selection criteria are met.

Patient Selection Criteria

Coverage eligibility will be considered for Tolsura (itraconazole) when the following criteria are met:

- Patient has a diagnosis of ONE of the following:
  - Aspergillosis, pulmonary and extrapulmonary, in patients who are intolerant of or who are refractory to amphotericin B therapy; OR
  - Blastomycosis, pulmonary and extrapulmonary; OR
  - Histoplasmosis, including chronic cavitary pulmonary disease and disseminated, non-meningeal histoplasmosis; AND
- Patient has tried and failed (e.g., intolerance or inadequate response) generic itraconazole capsules unless there is clinical evidence or patient history that suggests this alternative will be ineffective or cause an adverse reaction to the patient.

  *(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of Tolsura (itraconazole) when the patient has NOT tried and failed generic itraconazole capsules unless there is clinical evidence or patient history that suggests the use of Tolsura will be ineffective or cause an adverse reaction to the patient to be **not medically necessary.****

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of Tolsura (itraconazole) when the patient selection criteria is not met (with the exception of the denoted above as **not medically necessary****) to be **investigational.***

Background/Overview

Tolsura was approved by the Food and Drug Administration (FDA) via the 505(b)(2) pathway relying on safety and efficacy information for itraconazole capsules. It is indicated in immunocompromised and non-immunocompromised adult patients for the treatment of blastomycosis, pulmonary and extrapulmonary, histoplasmosis, including chronic cavitary pulmonary disease and disseminated, non-meningeal histoplasmosis, and aspergillosis, pulmonary and extrapulmonary, in patients who are intolerant of or who are refractory to amphotericin B. Itraconazole capsules (Sporanox®, generics) are also indicated for these uses and for the treatment of onychomycosis in non-immunocompromised patients while Tolsura is NOT indicated for the treatment of onychomycosis. A third formulation, itraconazole oral solution 100 mg/10 mL (Sporanox®, generics), is indicated for the treatment of oropharyngeal and esophageal candidiasis. The drug exposure with itraconazole oral solution is greater than that of the 100 mg capsules when the same dose of drug is given. Tolsura is NOT interchangeable or substitutable with these other itraconazole products. Tolsura is formulated using a novel process known as SUBA® (Super-Bioavailable) technology which uses a unique spray-drying process to disperse itraconazole into a polymer matrix which is then encapsulated into a hard gelatin capsule. The SUBA formulation doubles the bioavailability of conventional 100 mg itraconazole capsules into a smaller 65 mg dose. Tolsura is only available in 65mg capsules and its recommended dose is based on indication. The FDA approved dosage and administration recommendations may be found within Tolsura's prescribing information. Tolsura carries boxed warnings regarding congestive heart failure (CHF), cardiac effects, and drug interactions. Tolsura should not be administered to patients with evidence of ventricular dysfunction, such as CHF or a history of CHF, except for the treatment of life-threatening or other serious infections. Additionally, co-administration of Tolsura with drugs that either affect metabolism of itraconazole or whose metabolism is affected by itraconazole is contraindicated. Individuals with a known hypersensitivity to itraconazole should not receive Tolsura.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Tolsura was FDA approved in 2018 for the treatment of the following fungal infections in immunocompromised and non-immunocompromised adult patients: blastomycosis, pulmonary and extrapulmonary; histoplasmosis, including chronic cavitary pulmonary disease and disseminated, non-meningeal histoplasmosis; aspergillosis, pulmonary and extrapulmonary, in patients who are intolerant of or who are refractory to amphotericin B therapy.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

The rationale behind this policy is to ensure that Tolsura (itraconazole capsules) is being appropriately utilized based on FDA approval. This policy also ensures that generically available itraconazole is utilized, where possible.

References

1. Tolsura [package insert]. Mayne Pharma. Raleigh, North Carolina. Updated October 2024.
2. itraconazole capsule [package insert]. Various Manufacturers.

Policy History

Original Effective Date: 01/01/2026
Current Effective Date: 01/01/2026
10/02//2025 Medical Policy Committee review
10/08/2025 Medical Policy Implementation Committee approval. New policy.
Next Scheduled Review Date: 10/2026

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
    1. Consultation with technology evaluation center(s);
    2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
    3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.