Topical Antifungals for Onychomycosis Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-512-9004.
Provider Help Desk: 800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Jublia® (efinaconazole) and Kerydin® (tavaborole) will be considered when the following criteria are met:

1) Patient has a diagnosis of onychomycosis of the toenail(s) confirmed by a positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy (attach results) without dermatophytomas or lunula (matrix) involvement; and
2) Patient is 18 years of age or older; and
3) Patient has documentation of a complete trial and therapy failure or intolerance to oral terbinafine; and
4) Patient has documentation of a complete trial and therapy failure or intolerance to ciclopirox 8% topical solution; and
5) Patient is diabetic or immunosuppressed/immunocompromised. If the criteria for coverage are met, a one-time authorization of 48 weeks will be given. Requests for reoccurrence of infection will not be considered. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-preferred: ☐ Jublia ☐ Kerydin ☐ Tavaborole

Diagnosis (attach results of KOH preparation, fungal culture, or nail biopsy):

Dermatophytomas present? ☐ Yes ☐ No
Lunula (matrix) involvement? ☐ Yes ☐ No

Oral Terbinafine trial:
Dose: _____ Trial dates: _____
Failure reason: _____

Ciclopirox topical solution trial:
Dose: _____ Trial dates: _____
Failure reason: _____
Medical or contraindication reason to override trial requirements: _____

Is the patient diabetic? □ Yes □ No

Is the patient immunosuppressed or immunocompromised? □ Yes □ No
If yes, diagnosis: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____
Prescriber or authorized signature Date
*** Must match prescriber listed above**

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note*: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*