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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Topical Antifungals for Onychomycosis Prior Authorization of Benefits (PAB) Form Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

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 & MAY AFFECT THE OUTCOME of this request.

☐ Yes ☐ No Patient has documentation of a complete trial and therapy failure or intolerance to oral terbinafine
If No:
☐ Yes ☐ No Documented evidence is provided that use of these agents would be medically contraindicated

☐ Yes ☐ No Patient has documentation of a complete trial and therapy failure or intolerance to ciclopirox 8% topical solution **If No:**
☐ Yes ☐ No Documented evidence is provided that use of these agents would be medically contraindicated

☐ Yes ☐ No Patient has a diagnosis of onychomycosis of the toenail(s) confirmed by a positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy without dermatophytomas or lunula (matrix) involvement (results must be provided)

☐ Yes ☐ No Patient is diabetic or immunosuppressed/immunocompromised

☐ Yes ☐ No Patient is 18 years of age or older

9. PHYSICIAN SIGNATURE

_____ _____
Prescriber or Authorized Signature Date

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.