

Market Applicability/Effective Date														
Market	FL & FHK	FL MMA	FL LTC	GA	KS	KY	LA	MD	NJ	NV	NY	TN	TX	WA
Applicable	X	NA	NA	X	NA	X	X	X	X	X	X	NA	NA	X

Medications	Comments
Jublia	N/A
Kerydin	N/A

VERRIDE(S)

Prior Authorization of Benefits

If the reject is **Product Service Not Covered** due to *benefit exclusion (nail bed [finger/toe] fungus or onychomycosis)*, topical products for onychomycosis may not be approved regardless of below criteria.

APPROVAL DURATION

- Onychomycosis with no comorbidity or non-onychomycosis indications: **One (1) year**
- Onychomycosis with relevant comorbidity: **LIFETIME**

APPROVAL CRITERIA

Requests for topical products for onychomycosis for individuals with no relevant comorbidity (normal immune system, and no disorder which predisposes to infection in the extremities) may be approved if: :

- I. Request is for one of the following:
 - A. Jublia or Kerydin and use is for onychomycosis of toenail; **AND**
- II. Evidence of functional impairment (such as loss of one or more toenails, pain, or swelling) is present; **AND**
- III. Individual has a confirmed fungal infection based on physical exam; **AND**
- IV. Individual has had a **trial of, or is contraindicated to** oral itraconazole and terbinafine; **OR**
- V. Individual has used the requested topical product for onychomycosis within the previous 6 months.

Requests for topical products for onychomycosis for individuals with **a relevant comorbidity** (abnormal immune system [i.e. HIV positive, on immunosuppressant drugs] and/or disorder which predisposes to infection in the extremities [i.e. Diabetes]), may be approved if:

- I. Request is for one of the following:
- II. Jublia or Kerydin and use is for onychomycosis of the toenail; **AND** Individual has a confirmed fungal infection based on physical exam; **AND**

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

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- III. Individual has had a **trial of, or is contraindicated to** oral itraconazole and terbenafine; **OR**
- IV. Individual has used the requested topical product for onychomycosis within the previous 6 months.

Requests for uses other than those listed will be forwarded for medical review.

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