



Request for Prior Authorization
TOPICAL ANTIFUNGALS FOR ONYCHOMYCOSIS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

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...

Non-Preferred: [ ] Jublia [ ] Kerydin [ ] Tavaborole

Dosage instructions: \_\_\_\_\_ Quantity: \_\_\_\_\_ Days supply: \_\_\_\_\_

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.

Form with fields for Prescriber signature (Must match prescriber listed above.) and Date of submission

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.