PRIOR AUTHORIZATION REQUEST
Onychomycosis

PATIENT:		Prescriber:	
	Name______________________		Name______________________
	Address: ______________________		Address ______________________
	City, State, Zip_____________________		City, State, Zip______________________
	D.O.B. _____________________		Phone ______________________
	Member ID:___________ _____________		Fax ______________________
			NPI ______________________

Medication Requested:____________ Qty Requested: ____________

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - θ INITIAL → ***please answer questions 2 – 8***
   - θ CONTINUATION → ***please answer question 9***
2. θ Yes θ No Is the requested medication being used as a topical treatment of tinea pedis, tinea cruris, and tinea corporis?
3. θ Yes θ No Has the patient failed OR has a contraindication to terbinafine cream?
4. θ Yes θ No Has the patient failed AT LEAST ONE formulary topical antifungal agents (for example, clotrimazole, ciclopirox, econazole, ketoconazole, miconazole, etc.) OR has a contraindication to all formulary agents?
5. What is the diagnosis or indication?
   - θ Onychomycosis of the toenails → ***please answer questions 6 – 8***
   - θ All others ***(please specify):*****_______________________________________ _________________**
6. θ Yes θ No Does the patient have ONE of the following comorbidities: diabetes, HIV, immunosuppression (for example, receiving chemotherapy, taking long term oral corticosteroids, taking anti-rejection medications), peripheral vascular disease, or pain caused by the onychomycosis?
7. θ Yes θ No Has the patient failed TWO formulary antifungal agents indicated for onychomycosis (such as, ciclopirox, greseofulvin, itrazconazole and terbinafine tablets)?
8. θ Yes θ No Does the patient have a contraindication to ALL formulary antifungal agents indicated for onychomycosis (such as, ciclopirox, greseofulvin, itrazconazole and terbinafine tablets)?
9. θ Yes θ No Has the patient responded to therapy with the requested medication?

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If you have any questions, call: 800-753-2851

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Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B Physician Signature

______________________________________ ______________________
PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 800-753-2851