maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Onychomycosis Products

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1 Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?

[] Initial (If checked, go to 2)
[] Continuation (If checked, go to 14)

2 What drug is being requested?

[] luliconazole, Luzu (If checked, go to 3)

[] Jublia (If checked, go to 9)

[] tavaborole, Kerydin (If checked, go to 9)

If you have any questions, call: 1-888-258-8250

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3	What is the diagnosis or indication? [] Tinea pedis (If checked, go to 4) [] Tinea cruris (If checked, go to 4) [] Tinea corporis (If checked, go to 5) [] Other (If checked, no further questions)		
4	Is the patient greater than or equal to 12 years of age? [If yes, skip to question 6.] [If no, no further questions.]	Yes	No
5	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
6	Has the patient failed OR has a contraindication to terbinafine cream? [If no, no further questions.]	Yes	No
7	Has the patient failed AT LEAST ONE of the following formulary topical antifungal agents: A) clotrimazole, B) ciclopirox, C) econazole, D) ketoconazole, E) miconazole? [If yes, no further questions.]	Yes	No
8	Is the patient contraindicated to ALL of the following formulary agents: A) clotrimazole, B) ciclopirox, C) econazole, D) ketoconazole, E) miconazole? [No further questions.]	Yes	No
9	Is the patient greater than or equal to 6 year(s) of age? [If no, no further questions.]	Yes	No
10	What is the diagnosis or indication? [] Onychomycosis of the toenails (If checked, go to 11) [] Other (If checked, no further questions)		
11	Does the patient have ONE of the following comorbidities: A) diabetes, B) human immunodeficiency virus (HIV), C) immunosuppression (that is: receiving chemotherapy, taking long term oral corticosteroids, taking anti-rejection medications), D) peripheral vascular disease, E) pain caused by the onychomycosis? [If no, no further questions.]	Yes	No
12	Has the patient failed TWO of the following formulary antifungal agents indicated for onychomycosis: A) ciclopirox, B) griseofulvin, C) itraconazole, D) terbinafine tablets?	Yes	No

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	[If yes, no further questions.]		
13	Does the patient have a contraindication to ALL of the following formulary antifungal agents indicated for onychomycosis: A) ciclopirox, B) griseofulvin, C) itraconazole tablets, D) terbinafine tablets? [No further questions.]	Yes	No
14	Has the patient responded to therapy with the requested medication?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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.

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