# 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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

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)

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

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[] Jublia (If checked, go to 9)

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

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?<br>[If yes, skip to question 6.]<br>[If no, no further questions.] | Yes | No |
| 5 | Is the patient greater than or equal to 2 years of age?<br>[If no, no further questions.] | Yes | No |
| 6 | Has the patient failed OR has a contraindication to terbinafine cream?<br>[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?<br>[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?<br>[No further questions.] | Yes | No |
| 9 | Is the patient greater than or equal to 6 year(s) of age?<br>[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?<br>[If no, no further questions.] | Yes | No |

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| | | | |
|---|---|---|---|
| 12 | Has the patient failed TWO of the following formulary antifungal agents indicated for onychomycosis: A) ciclopirox, B) griseofulvin, C) itraconazole, D) terbinafine tablets?<br>[If yes, no further questions.] | Yes | No |
| 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?<br>[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.

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