



PRIOR AUTHORIZATION FORM Onychomycosis

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID # _____

BIRTHDATE _____

PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PROVIDER INFORMATION

NAME _____

NPI # _____

ADDRESS _____

PHONE # _____ FAX # _____

CONTACT NAME _____

PROVIDER SIGNATURE _____

Drug Requested: oral terbinafine (Lamisil®) itraconazole(Sporanox®) ciclopirox 8% (Penlac)
Duration of therapy: 6 weeks 12 weeks
Diagnosis _____ **ICD-9 code** _____
Please check one Initial Request Extension Request

Positive KOH nail scraping (please provide lab report, or if KOH performed in office, chart notes)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Medical History:		
Steroid-dependent disease (e.g. arthritis, COPD, asthma, etc)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Neutropenic or transplant	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Immunocompromised other (_____)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Peripheral Vascular Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Ventricular Dysfunction (e.g. CHF)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Liver Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Activities of Daily Living Compromised:		
Mobility (If yes, provide chart notes)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Dexterity (If yes, provide chart notes)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Working (If yes, provide chart notes)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Affected digit(s) (check one):		
<input type="checkbox"/> Fingernail(s) <input type="checkbox"/> Toenail(s) <input type="checkbox"/> Fingernail(s) and Toenail(s)		
Contraindication for the use of oral antifungal agent (_____)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

CLINICAL CRITERIA

- member is immunocompromised or has a history of peripheral vascular disease (e.g. diabetes), **and/or**
- activities of daily living (ADLs) are significantly compromised due to the infection **and**
- has a positive KOH test from a nail scraping or a positive pathogenic fungal culture documenting the presence of hyphae with a dermatophyte or candidal infection

One treatment course per 12 months will be allowed. An extended treatment course or more frequent therapy will be reviewed on an individual basis upon receipt of substantiating documentation. Penlac® will be limited to individuals with a contraindication or a significant drug interaction to an oral antifungal agent.

PLEASE NOTE: ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.

Refer to the MVP Formulary at www.mvphealthcare.com for those drugs that require prior authorization or are subject to quantity limits or step therapy.

FAX THIS REQUEST TO:

Commercial **1-800-376-6373**
 (HMO, EPO/PPO, Option Child, Healthy NY, Personal Plan, CompCare, ASO)

Medicare Part D **1-800-401-0915**
 (Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)