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.

PRESCRIBING PHYSICIAN INFORMATION

NAME _____

NPI # _____

ADDRESS _____

_____

PHONE #_____FAX #_____

CONTACT NAME _____

PROVIDER SIGNATURE _____

Drug Requested: □ oral terbinafine (Lamisil®), if >90 per 365 days □ itraconazole (Sporanox®) □Onmel □ ciclopirox 8% (Penlac) □Jublia □ Kerydin

Duration of therapy: □ 6 weeks □ 12 weeks □ 48 weeks □ Other

Diagnosis_____ **ICD-10 code** _____

Please check one □ **Initial Request** □ **Extension Request**

Positive KOH nail scraping *(please provide lab report, or if KOH performed in office, chart notes)*	❑ YES	❑ NO
Medical History:		
Steroid-dependent disease (e.g. arthritis, COPD, asthma, etc)	❑ YES	❑ NO
Neutropenic or transplant	❑ YES	❑ NO
Immunocompromised other (_____)	❑ YES	❑ NO
Diabetes	❑ YES	❑ NO
Peripheral Vascular Disease	❑ YES	❑ NO
Ventricular Dysfunction (e.g. CHF)	❑ YES	❑ NO
Liver Disease	❑ YES	❑ NO
Activities of Daily Living Compromised:		
Mobility *(If yes, provide chart notes)*	❑ YES	❑ NO
Dexterity *(If yes, provide chart notes)*	❑ YES	❑ NO
Working *(If yes,provide chart notes)*	❑ YES	❑ NO
Affected digit(s) (check one):		
□ Fingernail(s) □ Toenail(s) □ Fingernail(s) and Toenail(s)		
Contraindication for the use of oral antifungal agent (_____)	❑ YES	❑ 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
- For Onmel must have documentation that the use of generic itraconazole would not be appropriate

One treatment course per 12 months will be allowed. An automated edit will allow up to 90 units per 365 days of terbinafine. 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.*

FAX THIS REQUEST TO:

Commercial **1-800-376-6373**
(HMO, EPO/PPO, Exchange, Medicaid, Child Health Plus, ASO)

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

Effective February 2016