PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Jublia Kerydin - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Jublia Kerydin - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Jublia (efinaconazole) Kerydin (tavaborole) Tavaborole

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have a known adverse reaction to Jublia or Kerydin? Y N

[If yes, then no further questions.]

2. Does the patient have a positive potassium hydroxide (KOH) test? Y N

[Note: Documentation must be submitted.]

[If no, then no further questions.]

3.	Has the patient failed Ciclopirox topical solution 8 percent? Y N	
	[Note: Documentation must be submitted.]	
	[If no, then no further questions.]	
4.	Has the patient tried and failed two of the following formulary medications: A) Terbinafine, B) Itraconazole, C) Griseofulvin, D) Fluconazole? Y N	
	[Note: Documentation must be submitted.]	
	[If yes, then no further questions.]	
5.	Does the patient have a contraindication to all oral formulary medications? Y N	
	[Note: Documentation must be submitted.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date