Prior Authorization Request Form for
efinaconazole **(Jublia)** and tavaborole **(Kerydin)**

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ____________________ Physician Name: ____________________

Address: ____________________ Address: ____________________

____________________ ____________________

Sponsor ID # ____________________ Phone #: ____________________

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. Does the patient have a diagnosis of onychomycosis?	☐ Yes Proceed to question 2	☐ No Coverage not approved
2. Is the diagnosis of onychomycosis confirmed by either KOH preparation, fungal culture, nail biopsy, OR another assessment to confirm the diagnosis?	☐ Yes Proceed to question 3	☐ No Coverage not approved
3. Is the patient immunocompromised, or has a diagnosis of diabetes mellitus or peripheral vascular disease?	☐ Yes Proceed to question 4	☐ No Coverage not approved
4. Is there pain in the affected nail(s) or swelling and/or redness in the surrounding nail tissue?	☐ Yes Proceed to question 5	☐ No Coverage not approved
5. Has the patient tried and experienced therapeutic failure to ciclopirox (Penlac)?	☐ Yes Proceed to question 6	☐ No Coverage not approved
6. Has the patient tried and experienced therapeutic failure to itraconazole (Sporonox) or terbinafine (Lamisil)?	☐ Yes **SKIP** to question **9**	☐ No Proceed to question 7
7. Does the patient have a contraindication (such as renal impairment, pre-existing liver disease, or evidence of ventricular dysfunction, such as CHF) to itraconazole (Sporonox) OR terbinafine (Lamisil)?	☐ Yes **SKIP** to question **9**	☐ No Proceed to question 8
8. Has the patient experienced an adverse event or intolerance to itraconazole (Sporonox) OR terbinafine (Lamisil)?	☐ Yes Proceed to question 9	☐ No Coverage not approved
9. Is treatment being requested due to a medical condition and not for cosmetic purposes? *(Note: examples of a medical condition include the following: patients with a history of cellulitis of the lower extremity who have ipsilateral toenail onychomycosis; diabetic patients with additional risk factors for cellulitis; patients who experience pain/discomfort associated with the infected nail)*	☐ Yes Proceed to question 10	☐ No Coverage not approved
10. Is the patient's condition causing debility or disruption in their activities of daily living?	☐ Yes Proceed to question 11 on page 2	☐ No Coverage not approved

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Question	Yes	No
11. Has the patient had a previous trial of Jublia or Kerydin?	☐ Yes Proceed to question 12	☐ No Sign and date below
12. Has the patient used Jublia or Kerydin within the previous 24 months?	☐ Yes Proceed to question 13	☐ No Coverage not approved
13. Has the patient completed a full course of therapy with Jublia or Kerydin within the previous 30 days?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _______________ Date _______________

[10 August 2016]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: