

# ONYCHOMYCOSIS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

**Today’s Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today’s Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient’s Diagnosis:

<input type="checkbox"/> Onychomycosis (tinea unguium)	<input type="checkbox"/> Aspergillosis
<input type="checkbox"/> Oropharyngeal or esophageal candidiasis	<input type="checkbox"/> Prophylaxis against invasive aspergillosis
<input type="checkbox"/> Other (ICD code plus description): _____	

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

- For all requests:**
- Is the patient currently treated with the requested agent? .....  Yes  No  
If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required** .....  Yes  No
  - Does the patient have any FDA labeled contraindications to the requested agent? .....  Yes  No  
If yes, please specify contraindications: \_\_\_\_\_
  - Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** \_\_\_\_\_  
\_\_\_\_\_

- For Aspergillosis requests:**
- Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? .....  Yes  No
  - Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced, metastatic cancer? Please note, chart notes are required. ....  Yes  No
  - Is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? .....  Yes  No

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For Aspergillosis requests (continued):**

7. Has the patient tried and had an inadequate response to amphotericin B? .....  Yes  No  
 If no, does the patient have an intolerance or hypersensitivity to amphotericin B? .....  Yes  No  
 If yes, please explain intolerance or hypersensitivity \_\_\_\_\_  
 \_\_\_\_\_  
 If no, Does the patient have an FDA labeled contraindication to amphotericin B? .....  Yes  No  
 If yes, please explain contraindication: \_\_\_\_\_  
 \_\_\_\_\_

**For Onychomycosis (tinea unguium) requests:**

8. Has the diagnosis been confirmed by ONE of the following lab tests: potassium hydroxide (KOH) preparation, biopsy, fungal culture, periodic acid-Schiff (PAS) staining, or polymerase chain reaction (PCR) testing? **Please note, a copy of the lab results are required.** .....  Yes  No
9. Is treatment of the patient's onychomycosis medically necessary and not entirely for cosmetic reasons?.....  Yes  No
10. Is the fungal nail infection confirmed by laboratory testing (KOH preparation, fungal culture, periodic acid-Schiff [PAS] staining, or polymerase chain reaction [PCR] testing)? **Please note, lab results are required.**.....  Yes  No
11. If the requested agent is Ciclodan or ciclopirox 8% topical solution, will treatment include removal of the unattached, infected nail(s) by a health care professional? .....  Yes  No
12. If the requested agent is Sporanox, has the patient received treatment for onychomycosis with the requested agent within the past 12 months? .....  Yes  No

**For Prophylaxis against invasive aspergillosis requests:**

13. Has the patient had, or currently has, ONE of the following: a lung transplant, a hematologic disorder with poorly functioning neutrophils (e.g., aplastic anemia, myelodysplastic syndrome, acute leukemia with repeat and/or prolonged neutropenia, or a history of invasive aspergillosis prior to transplantation? .....  Yes  No

**For Jublia (efinaconazole), Kerydin (tavaborole), or Ciclodan (ciclopirox) requests:**

14. Has the patient tried and had an inadequate response to ONE oral antifungal agent (itraconazole, terbinafine)?.....  Yes  No  
 If yes, please specify agent: \_\_\_\_\_  
 If no, does the patient have an intolerance or hypersensitivity to ONE oral antifungal agent?.....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
 \_\_\_\_\_  
 If no, does the patient have an FDA labeled contraindication to ALL oral antifungal agents? .....  Yes  No  
 If yes, please specify contraindication: \_\_\_\_\_  
 \_\_\_\_\_  
 If no, are the oral antifungal agents not clinically appropriate?.....  Yes  No  
 If yes, please provide supporting information: \_\_\_\_\_  
 \_\_\_\_\_

**For brand Jublia, Kerydin, or Ciclodan requests:**

- Please submit chart notes to support the answers to the following questions:**

15. Does the patient have a medication history of use within the past 90 days with ONE generic antifungal onychomycosis agent? .....  Yes  No
16. Has the patient tried and had an inadequate response to ONE generic antifungal onychomycosis agent (itraconazole, terbinafine, ciclopirox)?.....  Yes  No
17. Was ONE generic antifungal onychomycosis agent (itraconazole, terbinafine, ciclopirox) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
18. Does the patient have an intolerance or hypersensitivity to ONE generic antifungal onychomycosis agent? .....  Yes  No
19. Does the patient have an FDA labeled contraindication to ALL generic antifungal onychomycosis agents? .....  Yes  No
20. Is ONE generic antifungal onychomycosis agent (itraconazole, terbinafine, ciclopirox) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? .....  Yes  No

**Please continue to the next page.**

