iowa total care | ia health link | Hawki | envolve Pharmacy Solutions

FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

Request for Prior Authorization
TOPICAL ANTIFUNGALS FOR ONYCHOMYCOSIS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Julia® (efinaconazole) and Kerydin® (tavaborole) will be considered when the following criteria are met: 1) Patient has a diagnosis of onychomycosis of the toenail(s) confirmed by a positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy (attach results) without dermatophytomas or lunula (matrix) involvement; and 2) Patient is 18 years of age or older; and 3) Patient has documentation of a complete trial and therapy failure or intolerance to oral terbinafine; and 4) Patient has documentation of a complete trial and therapy failure or intolerance to ciclopirox 8% topical solution; and 5) Patient is diabetic or immunosuppressed/immunocompromised. If the criteria for coverage are met, a one-time authorization of 48 weeks will be given. Requests for reoccurrence of infection will not be considered. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred: ☐ Julia ☐ Kerydin ☐ Tavaborole

Dosage instructions:_____ **Quantity:**_____ **Days supply:**_____

Diagnosis (attach results of KOH preparation, fungal culture, or nail biopsy):_____

Dermatophytomas present? ☐ Yes ☐ No Lunula (matrix) involvement? ☐ Yes ☐ No

Oral Terbinafine trial: Dose:_____ Trial dates:_____

Failure reason:_____

Ciclopirox topical solution trial: Dose:_____ Trial Dates:_____

Failure reason:_____

Medical or contraindication reason to override trial requirements:_____

_____

Is the patient diabetic? ☐ Yes ☐ No

Is the patient immunosuppressed or immunocompromised? ☐ Yes ☐ No

If yes, diagnosis:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*