PRIOR AUTHORIZATION FORM
TOPICAL ANTIFUNGAL AGENTS

Ciclopirox (Penlac®, CNL-8™), efinaconazole (Julia®), lulizonazole (Luzu®)

Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Requests for prior authorization (PA) must include patient name, Medicaid ID #, drug name and appropriate clinical information to support the request on the basis of medical necessity.
Please include all requested information; incomplete forms will delay the PA process.

The completed form may be faxed to 1-844-512-7020 for Retail Pharmacy or 1-844-512-7022 for Medical Injectables.
All questions must be answered.

Today's Date: ___ ___/___ ___/___ ___ ___ ___ Requested Start Date: ___ ___/___ ___/___ ___ ___ ___

PATIENT INFORMATION

Name: (Last, First) _____ **Medicaid ID#:** _____

Date of Birth: ___ ___/___ ___/___ ___ ___ ___ **Gender:** ☐ **Male** ☐ **Female**

DRUG INFORMATION

Drug Name / Form: _____ **Strength:** _____

Dosing Frequency: _____ **Length of Therapy:** _____

Quantity per Day: _____

DIAGNOSIS AND MEDICAL INFORMATION – Please Answer All Questions To Facilitate Processing

Topical Onychomycosis Agents - to receive a ONE (1) year approval for these drugs, please complete the questions below.

Does the patient meet the following criteria?

Diagnosis of onychomycosis?	☐ Yes ☐ No
Diagnosis of athlete's foot (tinea pedis) or ringworm (tinea cruris, tinea corporis)?	☐ Yes ☐ No
Is the patient 18 years of age or older?	☐ Yes ☐ No
Penlac®, CNL-8™, Julia®: must have failure of an adequate trial of one oral alternative - terbinafine (6 weeks for fingernail infections; 1 week for toenail infections); fluconazole (6 months); itraconazole (60 days for fingernail infections; 90 days for toenail)	☐ Yes ☐ No
Luzu®: must have failure of an adequate trial of two (2) preferred topical antifungal medications, OR	☐ Yes ☐ No
Allergy or contraindication to oral terbinafine, fluconazole or itraconazole	☐ Yes ☐ No

MEDICAL NECESSITY: Provide clinical evidence that supports the use of the requested medication.

PRESCRIBER INFORMATION

Name/Specialty (print):_____ NPI Number: _____

Phone Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Signature of Prescribing Provider: _____ Date_____

PLEASE INCLUDE ALL REQUESTED INFORMATION.
INCOMPLETE FORMS WILL DELAY THE PRIOR AUTHORIZATION PROCESS.

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PRIOR AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE.