SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Topical Antifungals (Non-Preferred)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Diagnosis: Topical Onychomycosis Agents

Authorization Approval Length: ONE (1) Year

Does the patient meet the following criteria?

1) Diagnosis of onychomycosis? ❑ Yes ❑ No
2) Diagnosis of athlete's foot (tinea pedis) or ringworm (tinea cruris, tinea corporis) ❑ Yes ❑ No
3) Is the patient 18 years of age or older? ❑ Yes ❑ No

(Continued on next page)

4) **Penlac®, CNL-8™, Jublia®**: must have failure of an adequate trial of 1 oral alternative:

❑ Yes ❑ No

- **terbinafine** (**6** weeks for **fingernail** infections; **12** weeks for **toenail** infections);
- **fluconazole** (6 months);
- **itraconazole** (**60** days for **fingernail** infections; **90** days for **toenail** infections)

5) **Luzu®** and **luliconazole** (generic): must have failure of an adequate trial of **two (2) preferred** topical antifungal medications ❑ Yes ❑ No

OR

6) Allergy or contraindication to oral terbinafine, fluconazole or itraconazole? ❑ Yes ❑ No

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

_____

_____

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Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

REVISED/UPDATED/REFORMATTED: ~~6/320/2017~~; ~~9/1/2017~~; ~~8/31/2018~~; ~~(Rev) 4/11/2019~~; ~~6/18/2019~~; ~~06/29/21~~ **11/15/2023**