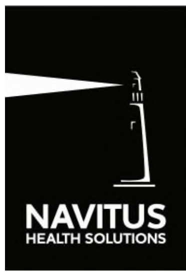


TEXAS MEDICAID
Clinical Edit Prior Authorization
Topical Antifungals for Onychomycosis

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: ______________________________________ ICD 10 Code: ___________

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ Preferred Drug **(Go to Step 4)**

OR ☐ No Status, Drug is not in a Market Basket **(Go to Step 4)**

OR ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the last 180 days?

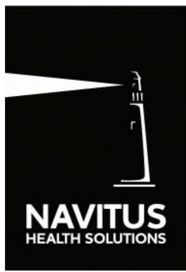
   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Deny)



STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of onychomycosis of the toenail (tinea unguium) in the last 730 days?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Has the client had 180 days therapy with the requested agent in the last 365 days?

   ☐ Yes (Go to #3) ☐ No (Go to #4)

3. Does the client have a diagnosis that might compromise their immune system (e.g. diabetes, peripheral vascular insufficiency or immune deficiency due to medical condition or treatment) in the last 730 days?

   ☐ Yes (Approve – 365 days) ☐ No (Deny)

4. Is the client greater than or equal to (≥) 6 years of age?

   ☐ Yes (And the request is for JUBLIA or KERYDIN, go to #6)
   ☐ Yes (And the request is for ciclopirox solution, go to #5)
   ☐ No (Deny)

5. Is the client greater than or equal to (≥) 12 years of age?

   ☐ Yes (Go to #6) ☐ No (Deny)

6. Has the client had at least 12 weeks of treatment with an oral antifungal agent for onychomycosis in the last 180 days or does the client have a contraindication to oral therapy or has the client had a severe adverse reaction to oral antifungal agents for onychomycosis?

   Examples of an oral antifungal agent for onychomycosis include griseofulvin, itraconazole (SPORANOX) and terbinafine.

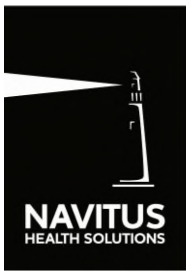
   ☐ Yes (Approve – 365 days) ☐ No (Go to #7)

7. Does the client have a diagnosis of active or chronic hepatic disease, lymphocytopenia or neutropenia in the last 90 days?

   ☐ Yes (Approve – 365 days) ☐ No (Go to #8)

8. Does the client have a diagnosis of lupus in the last 365 days?

   ☐ Yes (Approve – 365 days) ☐ No (Deny)



STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: ____ **Date:** ____________

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.