

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
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:

Jublia® (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.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Non-Preferred:

Jublia Kerydin

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: _____

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Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

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.

Check www.amerihhealthcaritasia.com/Provider to confirm your version of this form.