Prior Authorization Form

CAREFIRST

Kerydin

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Kerydin.

Drug Name (select from list of drugs shown)

Kerydin (tavaborole topical solution) Tavaborole Topical Solution

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the requested drug being prescribed for onychomycosis of the toenail(s) due to Trichophyton rubrum or Trichophyton mentagrophytes?	Y N
	[If Yes, then go to 2. If No, then no further questions.]	
2.	Has the patient's diagnosis been confirmed with a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy)?	Y N
	[If Yes, then go to 3. If No, then no further questions.]	
3.	Has the patient experienced an inadequate treatment response to an oral antifungal therapy (e.g., terbinafine,	Y N

	itraconazole)?	
	[If Yes, then go to 6. If No, then go to 4.]	
4.	Has the patient experienced an intolerance to an oral antifungal therapy (e.g., terbinafine, itraconazole)?	Y N
	[If Yes, then go to 6. If No, then go to 5.]	
5.	Does the patient have a contraindication that would prohibit a trial of an oral antifungal therapy (e.g., terbinafine, itraconazole)?	Y N
	[If Yes, then go to 6. If No, then no further questions.]	
6.	Is the requested drug being used in a footbath?	Y N
	[If Yes, then no further questions. If No, then go to 7.]	
7.	Does the patient require MORE than the plan allowance of 4 mL per month?	Y N
	[NOTE: If higher quantities are needed, additional questions are required.]	
	[If Yes, then go to 8. If No, then no further questions.]	
8.	Are multiple toenails being treated?	Y N
	[If Yes, then go to 9. If No, then no further questions.]	
9.	Does the patient require MORE than the plan allowance of 20 mL per month?	Y N
	[No further questions.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date