PA Request Criteria

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**CAREFIRST ASO**
**Antifungals Topical Limit-Post Limit**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Antifungals Topical Limit-Post Limit.

**Patient Name:** _____ **Date:** 11/27/2023
**Patient ID:** _____ **Patient Date Of Birth:** _____
**Patient Group No:** _____ **Patient Phone:** _____ **Physician Name:**
**NPI#:** **Specialty:**
**Physician Office Address:** _____ **Physician Office Telephone:**
_

**Drug Name (specify drug)** _____

**Quantity:** _____ **Frequency:** _____ **Strength:** _____

**Route of Administration:** _____ **Expected Length of Therapy:** _____

**Diagnosis:** _____ **ICD Code:** _____

**Comments:** _____
_____
_____

**Please check the appropriate answer for each applicable question.**

1. Is the requested drug being used in a footbath? **Y** ☐ **N** ☐

2. Is the requested drug being prescribed for the treatment of Candidiasis/Candida? **Y** ☐ **N** ☐

3. Which drug is being requested (applies to brand or generic)? Please check the drug being requested.
   - ciclopirox cream (Loprox cream) (If checked, go to 18) ☐
   - ciclopirox suspension/lotion (Loprox suspension/lotion) (If checked, go to 18) ☐
   - clotrimazole cream, solution (If checked, go to 18) ☐
   - econazole cream (If checked, go to 15) ☐
   - ketoconazole cream (If checked, go to 18) ☐
   - miconazole-zinc oxide-white petrolatum ointment (Vusion) (If checked, go to 17) ☐
   - nystatin cream, ointment, powder (If checked, go to 18) ☐
   - None of the above (If checked, no further questions) ☐

4. Is the requested drug being prescribed for the treatment of Seborrheic Dermatitis? **Y** ☐ **N** ☐

5. Which drug is being requested (applies to brand or generic)? Please check the drug being requested.
   - ciclopirox gel (If checked, go to 18) ☐
   - ciclopirox shampoo (Loprox shampoo) (If checked, go to 18) ☐
   - ketoconazole cream (If checked, go to 18) ☐
   - ketoconazole foam (Extina) (If checked, go to 17) ☐
   - ketoconazole gel (Xolegel) (If checked, go to 14) ☐
   - ketoconazole shampoo (If checked, go to 18) ☐

None of the above (If checked, no further questions) ☐

6. Is the requested drug being prescribed for the treatment of Tinea (Pityriasis) Versicolor? **Y** ☐ **N** ☐

7. Which drug is being requested (applies to brand or generic)? Please check the drug being requested.

- butenafine cream (Mentax) (If checked, go to 15) ☐
- ciclopirox cream (Loprox cream) (If checked, go to 18) ☐
- ciclopirox suspension/lotion (Loprox suspension/lotion) (If checked, go to 18) ☐
- clotrimazole cream, solution (If checked, go to 18) ☐
- econazole cream (If checked, go to 15) ☐
- ketoconazole cream (If checked, go to 18) ☐
- ketoconazole shampoo (If checked, go to 18) ☐
- oxiconazole cream (Oxistat cream) (If checked, go to 15) ☐
- sulconazole cream, solution (Exelderm) (If checked, go to 15) ☐
- None of the above (If checked, no further questions) ☐

8. Is the requested drug being prescribed for the treatment of Tinea Corporis? **Y** ☐ **N** ☐

9. Which drug is being requested (applies to brand or generic)? Please check the drug being requested.

- ciclopirox cream (Loprox cream) (If checked, go to 18) ☐
- ciclopirox gel (If checked, go to 18) ☐
- ciclopirox suspension/lotion (Loprox suspension/lotion) (If checked, go to 18) ☐
- clotrimazole cream, solution (If checked, go to 18) ☐
- econazole cream (If checked, go to 15) ☐
- ketoconazole cream (If checked, go to 18) ☐
- luliconazole cream (Luzu) (If checked, go to 15) ☐
- naftifine cream (If checked, go to 15) ☐
- naftifine 1 percent gel (Naftin 1 percent gel) (If checked, go to 18) ☐
- oxiconazole cream, lotion (Oxistat) (If checked, go to 15) ☐
- sulconazole cream, solution (Exelderm) (If checked, go to 15) ☐
- None of the above (If checked, no further questions) ☐

10. Is the requested drug being prescribed for the treatment of Tinea Pedis? **Y** ☐ **N** ☐

11. Which drug is being requested (applies to brand or generic)? Please check the drug being requested.

- ciclopirox cream (Loprox cream) (If checked, go to 18) ☐
- ciclopirox gel (If checked, go to 18) ☐
- ciclopirox suspension/lotion (Loprox suspension/lotion) (If checked, go to 18) ☐
- clotrimazole cream, solution (If checked, go to 18) ☐
- econazole cream (If checked, go to 15) ☐
- econazole foam (Ecoza) (If checked, go to 16) ☐

ketoconazole cream (If checked, go to 18) ☐

luliconazole cream (Luzu) (If checked, go to 15) ☐

naftifine cream (If checked, go to 15) ☐

naftifine 1 percent gel (Naftin 1 percent gel) (If checked, go to 18) ☐

naftifine 2 percent gel (Naftin 2 percent gel) (If checked, go to 15) ☐

oxiconazole cream, lotion (Oxistat) (If checked, go to 15) ☐

sertaconazole cream (Ertaczo) (If checked, go to 15) ☐

sulconazole cream (Exelderm cream) (If checked, go to 15) ☐

None of the above (If checked, no further questions) ☐

12. Is the requested drug being prescribed for the treatment of Tinea Cruris? **Y** ☐ **N** ☐

13. Which drug is being requested (applies to brand or generic)? Please check the drug being requested.

ciclopirox cream (Loprox cream) (If checked, go to 18) ☐

ciclopirox suspension/lotion (Loprox suspension/lotion) (If checked, go to 18) ☐

clotrimazole cream, solution (If checked, go to 18) ☐

econazole cream (If checked, go to 15) ☐

ketoconazole cream (If checked, go to 18) ☐

luliconazole cream (Luzu) (If checked, go to 15) ☐

naftifine cream (If checked, go to 15) ☐

naftifine 1 percent gel (Naftin 1 percent gel) (If checked, go to 18) ☐

oxiconazole cream, lotion (Oxistat) (If checked, go to 15) ☐

sulconazole cream, solution (Exelderm) (If checked, go to 15) ☐

None of the above (If checked, no further questions) ☐

14. Is this request for more than 90 grams per month? **Y** ☐ **N** ☐

15. Is this request for more than 120 grams or milliliters per month? **Y** ☐ **N** ☐

16. Is this request for more than 140 grams per month? **Y** ☐ **N** ☐

17. Is this request for more than 200 grams per month? **Y** ☐ **N** ☐

18. Is this request for more than 240 grams or milliliters per month? **Y** ☐ **N** ☐

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**

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