

Pre - PA Allowance

None

Prior-Approval Requirements

Age 12 years of age or older

Diagnosis

Patient must have the following:

Interdigital Tinea Pedis

AND ALL of the following:

1. Suspected infection of **ONE** of the following fungal species:
 - a. *Trichophyton rubrum*
 - b. *Trichophyton mentagrophytes*
 - c. *Epidermophyton floccosum*
2. Inadequate treatment response, intolerance, or contraindication to a topical or oral antifungal legend medication (e.g., fluconazole, terbinafine, ketoconazole, etc.)
3. **NOT** immunocompromised

Prior - Approval Limits

Quantity 60 units

Duration 1 month

Prior – Approval *Renewal* Requirements

Age 12 years of age or older

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**BlueCross
BlueShield**

Federal Employee Program.

**ERTACZO
(sertaconazole)**

2. **NOT** immunocompromised

Prior - Approval *Renewal* Limits

Same as above