BlueCross BlueShield
Federal Employee Program

TOPICAL ANTIFUNGALS
Jublia (efinaconazole), **Kerydin** (tavaborole)

Pre - PA Allowance

None

Prior-Approval Requirements

Age 6 years of age and older

Diagnosis

Patient must have the following:

Onychomycosis of the toenail(s)

AND ALL of the following:

1. Laboratory **AND** clinical documentation of **ONE** of the infections:
   a. *Trichophyton rubrum*
   b. *Trichophyton mentagrophytes*
2. Inadequate treatment response, intolerance, or contraindication to a prescription oral therapy (e.g., terbinafine, itraconazole, griseofulvin)
3. Inadequate treatment response, intolerance, or contraindication to a topical antifungal therapy (e.g., ciclopirox)

Prior - Approval Limits

Quantity Limit

Medication	Quantity
Jublia 4 mL	4 bottles per 84 days **OR**
Jublia 8 mL	2 bottles per 84 days **OR**
Kerydin 4 mL	5 bottles per 84 days **OR**
Kerydin 10 mL	2 bottles per 84 days

Duration 12 months

Prior – Approval *Renewal* Requirements

None

Prior - Approval *Renewal* Limits

None