USFHP Prior Authorization Request Form for efinaconazole **(Jublia)** and tavaborole **(Kerydin)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior Authorization expires after one year. Clinical documentation may be required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a diagnosis of onychomycosis?	☐ Yes Proceed to question 2	☐ No Coverage not approved
2. Is the diagnosis of onychomycosis confirmed by either KOH preparation, fungal culture, nail biopsy, OR another assessment to confirm the diagnosis?	☐ Yes Proceed to question 3	☐ No Coverage not approved
3. Is the patient immunocompromised, or has a diagnosis of diabetes mellitus or peripheral vascular disease?	☐ Yes Proceed to question 4	☐ No Coverage not approved
4. Is there pain in the affected nail(s) or swelling and/or redness in the surrounding nail tissue?	☐ Yes Proceed to question 5	☐ No Coverage not approved
5. Has the patient tried and experienced therapeutic failure to ciclopirox (Penlac)?	☐ Yes Proceed to question 6	☐ No Coverage not approved
6. Has the patient tried and experienced therapeutic failure to itraconazole (Sporonox) or terbinafine (Lamisil)?	☐ Yes **SKIP** to question **9**	☐ No Proceed to question 7
7. Does the patient have a contraindication (such as renal impairment, pre-existing liver disease, or evidence of ventricular dysfunction, such as CHF) to itraconazole (Sporonox) OR terbinafine (Lamisil)?	☐ Yes **SKIP** to question **9**	☐ No Proceed to question 8
8. Has the patient experienced an adverse event or intolerance to itraconazole (Sporonox) OR terbinafine (Lamisil)?	☐ Yes Proceed to question 9	☐ No Coverage not approved
9. Is treatment being requested due to a medical condition and not for cosmetic purposes*?* *(Note: examples of a medical condition include the following: patients with a history of cellulitis of the lower extremity who have ipsilateral toenail onychomycosis; diabetic patients with additional risk factors for cellulitis; patients who experience pain/discomfort associated with the infected nail)*	☐ Yes Proceed to question 10	☐ No Coverage not approved
10. Is the patient's condition causing debility or disruption in their activities of daily living?	☐ Yes Proceed to question 11 on page 2	☐ No Coverage not approved

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11. Has the patient had a previous trial of Jublia or Kerydin?	☐ Yes Proceed to question 12	☐ No Sign and date below
12. Has the patient used Jublia or Kerydin within the previous 24 months?	☐ Yes Proceed to question 13	☐ No Sign and date below
13. Has the patient completed a full course of therapy with Jublia or Kerydin within the previous 30 days?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[22 September 2023]