1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Ciclodan® Solution Kit, Ciclopirox Kit, and CNL8 Nail Kit Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Onychomycosis of the fingernail(s)
❑ Onychomycosis of the toenail(s)
❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical information:

Does the patient have dermatophytomas or lunula (matrix) involvement? ❑ **Yes** ❑ **No**

Has the diagnosis of fingernail/toenail onychomycosis been confirmed by positive potassium hydroxide (KOH) preparation, culture, or histology? ❑ **Yes** ❑ **No**

Is the patient's condition causing debility or a disruption in the activities of daily living? ❑ **Yes** ❑ **No**

Toenail onychomycosis:

Does the patient have mild to moderate disease defined by the presence of ALL of the following: Involvement of at least 1 great toenail, the target great toenail (TGT) includes at least a 3 mm section of clear nail (measured from the proximal nail fold) and less than or equal to a 3 mm distal toenail plate thickness, and 20% to 65% clinical involvement of the target toenail? ❑ **Yes** ❑ **No**

Medication history:

Does the patient have a history of failure, contraindication, or intolerance to oral terbinafine? ❑ **Yes** ❑ **No**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	