

## Ciclodan<sup>®</sup> 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 Nan	Provider Name:			
Insurance ID#:			NPI#:		Specialty:		
Date of Birth:			Office Phone	Office Phone:			
Street Address:			Office Fax:	Office Fax:			
City:	State:	Zip:	Office Street	Office Street Address:			
Phone:			City:	State:	Zip:		
Medication Information (required)							
Medication Name:			Strength:		Dosage Form:		
Check if requesting brand			Directions for	Directions for Use:			
Check if request is	for continuation	of therapy					
Clinical Information (required)							
Select the diagnos	sis below:						
Onychomycosis							
Other diagnosis:ICD-10 Code(s):							
Clinical informatio							
Does the patient have dermatophytomas or lunula (matrix) involvement? D Yes D No							
Has the diagnosis of fingernail/toenail onychomycosis been confirmed by positive potassium hydroxide (KOH) preparation, culture, or histology? <b>D</b> Yes <b>D</b> No							
Is the patient's condition causing debility or a disruption in the activities of daily living?  Yes  No							
Toenail onychomy	cosis:						
Does the patient have mild to moderate disease defined by the presence of <u>ALL</u> 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? <b>D</b> Yes <b>D</b> No							
Medication history		failure, contraindicatior	o, or intolerance to	oral terbinafine?	] Yes 🗆 No		



Date:

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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.				
	Discourse to the base fits were limited as a shake a second of the set fits we disc there in the limit does not set of any this form.				
	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):

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

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