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

Julia® 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 toenail(s)
❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical information:

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

Please select if the diagnosis is confirmed by one of the following:

❑ Fungal culture
❑ Histology
❑ Nail biopsy
❑ Positive potassium hydroxide (KOH) test

Are medical records confirming the diagnosis of onychomycosis being submitted along with this fax (if request is for a subsequent course of therapy a new test must be performed)? ❑ **Yes** ❑ **No**

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 50% clinical involvement of the target toenail? ❑ **Yes** ❑ **No**

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

Is the treatment being requested due to a medical condition and not for cosmetic purposes (e.g., patients with history of cellulitis of the lower extremity who have ipsilateral toenail onychomycosis, patients with diabetes who have additional risk factors for cellulitis, patients who experience pain/discomfort associated with the infected nail)? ❑ **Yes** ❑ **No**

***Please note: Chart documentation is required to be submitted to ProAct® along with this fax*

Medication history:

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Itraconazole (generic Sporanox)
❑ Oral terbinafine (generic Lamisil)

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Patient requires a larger quantity to cover a larger surface area
❑ Other: _____

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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:	