



COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

TOPICAL ANTIFUNGAL AGENTS:

CICLOPIROX (PENLAC[®], CNL-8[™]), EFINACONAZOLE (JUBLIA[®]), LULIZONAZOLE (LUZU[®]),
TAVABOROLE (KERYDIN[®])

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Member's First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DIAGNOSIS AND MEDICAL INFORMATION

TOPICAL ONYCHOMYCOSIS AGENTS – to receive a ONE (1)-year approval, complete the following questions.

1. Diagnosis of onychomycosis?
 Yes No
2. Diagnosis of athlete's foot (tinea pedis) or ringworm (tinea cruris, tinea corporis)?
 Yes No
3. Is the member 18 years of age or older?
 Yes No
4. **Penlac®, CNL-8™, Jublia®:** must have failure of an adequate trial of **ONE** oral alternative – terbinafine (6 weeks for fingernail infections; 1 week for toenail infections); fluconazole (6 months); itraconazole (60 days for fingernail infections; 90 days for toenail infections).
 Yes No
5. **Luzu®:** must have failure of an adequate trial of **TWO** preferred topical antifungal medications; **OR**
 Yes No
6. Allergy or contraindication to oral terbinafine, fluconazole, or itraconazole?
 Yes No
7. **Medical Necessity:** Provide clinical evidence that supports the use of the requested medication.

Prescriber Signature (Required)

Date

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Magellan Medicaid Administration / ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060