AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Onychomycosis (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.

When conditions are met, we will authorize the coverage of Onychomycosis (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Jublia (efinaconazole)   Kerydin (tavaborole)

Other, please specify_____

Quantity _____   Frequency _____   Strength _____

Route of Administration _____   Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.:   _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____   NPI Number: _____

Physician Fax: _____   Physician Phone: _____

Physician Address: _____   City, State, Zip: _____

Diagnosis:_____   **ICD Code:**_____

Please circle the appropriate answer for each question.

1. Has the diagnosis of onychomycosis of the toenail been confirmed   Y   N
   with one of the following: A) KOH preparation test, B) Fungal
   culture, C) Nail biopsy?

   [If no, then no further questions.]

2. Is the requested drug being prescribed for treatment of   Y   N
   onychomycosis of the toenails for a patient with one of the following
   medical conditions: A) Diabetes, B) HIV, C) Immunosuppression, D)
   Peripheral vascular disease, E) Pain caused by the onychomycosis?

   [If no, then no further questions.]

3. Has the patient experienced an inadequate treatment response,   Y   N
intolerance, or contraindication to 2 formulary antifungal agents (i.e.
ciclopirox, itraconazole, oral terbinafine)?

[If no, then no further questions.]

4. Is the patient 18 years of age or older?   Y   N

Comments:

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature   Date