



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations. Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service. Please note: All information below is required to process this request. Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Jublia® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

### Clinical Information (required)

**Select the diagnosis below:**

- Onychomycosis of the toenail(s)  
 Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**Confirmation of diagnosis:**

Is the patient's diagnosis confirmed by one of the following?  Yes  No

- Culture
- Histology
- Positive potassium hydroxide (KOH) preparation

Are medical records (laboratory and clinical documentation) confirming the patient's diagnosis with the infection of Trichophyton rubrum or Trichophyton mentagrophytes being submitted along with this fax (if request is for a subsequent course of therapy a new test must be performed)?  Yes  No

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

**Clinical information:**

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

Does the patient have mild to moderate disease involving at least one great toenail?  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

**Select the medications the patient has had a trial and failure, contraindication, or intolerance to (Document date and duration of trials):**

- |   |             |                          |
|---|-------------|--------------------------|
| <input type="checkbox"/> Ciclopirox (generic Penlac)        | Date: _____ | Duration of trial: _____ |
| <input type="checkbox"/> Itraconazole (generic Sporanox)    | Date: _____ | Duration of trial: _____ |
| <input type="checkbox"/> Kerydin                            | Date: _____ | Duration of trial: _____ |
| <input type="checkbox"/> Oral terbinafine (generic Lamisil) | Date: _____ | Duration of trial: _____ |

**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.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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