OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit 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

Kerydin® Prior Authorization Request Form

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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): _____

Confirmation of diagnosis:
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:
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):
❑ Ciclopirox (generic Penlac) Date: _____ Duration of trial: _____
❑ Itraconazole (generic Sporanox) Date: _____ Duration of trial: _____
❑ Oral terbinafine (generic Lamisil) Date: _____ Duration of trial: _____

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: _____

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.