



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

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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Ciclopirox Solution Products Prior Authorization Request Form

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Onychomycosis of the fingernails</p> <p><input type="checkbox"/> Onychomycosis of the toenails</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>Clinical information:</p> <p>Does the patient have dermatophytomas or lunula (matrix) involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have mild to moderate disease involving at least one great toenail? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the diagnosis of onychomycosis been confirmed by one of the following? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> • Culture • Histology • Positive potassium hydroxide (KOH) preparation
<p>Select the medications the patient has a failure, contraindication, or intolerance to:</p> <p><input type="checkbox"/> Itraconazole</p> <p><input type="checkbox"/> Jublia</p> <p><input type="checkbox"/> Kerydin</p> <p><input type="checkbox"/> Lamisil</p> <p><input type="checkbox"/> Oral terbinafine</p> <p><input type="checkbox"/> Sporanox</p>

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.
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
 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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