CAREFIRST
Kerydin

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Kerydin.

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Tavaborole Kerydin (tavaborole topical solution)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for onychomycosis of the toenail(s) due to Trichophyton rubrum or Trichophyton mentagrophytes?	**Y** ☐	**N** ☐
2.	Has the patient's diagnosis been confirmed with a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy)?	**Y** ☐	**N** ☐
3.	Has the patient experienced an inadequate treatment response to an oral antifungal therapy (e.g., terbinafine, itraconazole)?	**Y** ☐	**N** ☐
4.	Has the patient experienced an intolerance to an oral antifungal therapy (e.g., terbinafine, itraconazole)?	**Y** ☐	**N** ☐
5.	Does the patient have a contraindication that would prohibit a trial of an oral antifungal therapy (e.g., terbinafine, itraconazole)?	**Y** ☐	**N** ☐
6.	Is the requested drug being used in a footbath?	**Y** ☐	**N** ☐
7.	Does the patient require MORE than the plan allowance of 4 mL per month?	**Y** ☐	**N** ☐
8.	Are multiple toenails being treated?	**Y** ☐	**N** ☐
9.	Does the patient require MORE than the plan allowance of 20 mL per month?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date