



COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

TOPICAL ANTIFUNGAL AGENTS:

CICLOPIROX (PENLAC<sup>®</sup>, CNL-8<sup>™</sup>), EFINACONAZOLE (JUBLIA<sup>®</sup>), LULIZONAZOLE (LUZU<sup>®</sup>),  
TAVABOROLE (KERYDIN<sup>®</sup>)

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

**MEMBER INFORMATION**

Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender: ☐ Male ☐ Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**DRUG INFORMATION**

Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

(Form continued on next page.)

Member's Last Name:

--	--	--	--	--	--	--	--	--	--	--	--

Member's First Name:

--	--	--	--	--	--	--	--	--	--	--	--

**DIAGNOSIS AND MEDICAL INFORMATION**

---

**TOPICAL ONYCHOMYCOSIS AGENTS – to receive a ONE (1)-year approval, complete the following questions.**

1. Diagnosis of onychomycosis?

☐ Yes ☐ No

2. Diagnosis of athlete's foot (tinea pedis) or ringworm (tinea cruris, tinea corporis)?

☐ Yes ☐ No

3. Is the member 18 years of age or older?

☐ Yes ☐ No4. **Penlac®**, **CNL-8™**, **Jublia®**: must have failure of an adequate trial of **ONE** oral alternative – terbinafine (6 weeks for fingernail infections; 1 week for toenail infections); fluconazole (6 months); itraconazole (60 days for fingernail infections; 90 days for toenail infections).☐ Yes ☐ No5. **Luzu®**: must have failure of an adequate trial of **TWO** preferred topical antifungal medications; **OR**☐ Yes ☐ No

6. Allergy or contraindication to oral terbinafine, fluconazole, or itraconazole?

☐ Yes ☐ No7. **Medical Necessity:** Provide clinical evidence that supports the use of the requested medication.

---

---

---

---

---

**Prescriber Signature (Required)****Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; Incomplete forms will delay the SA process.**

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826