



Please note: All information below is required to process this request.
 Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern



Jublia® & Kerydin® Prior Authorization Request Form
 DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>	Provider Information <small>(required)</small>
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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>
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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>
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Select the requested drug below:
 Jublia Kerydin

What is the patient's diagnosis for the medication being requested? _____
 ICD-10 Code(s): _____

Clinical information:
 Has the patient tried and failed at least 48 weeks (consecutive) of therapy with ciclopirox 8% nail lacquer (generic Penlac)? Yes No

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****
Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: _____ **Date:** _____

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.