



Onychomycosis Prior Authorization Request

Fax the completed form to (816) 271-1228
or mail to 137 North Belt Highway, St. Joseph, MO 64506.

Questions? Call (816) 271-4019 or (800) 447-5819.

Provider Information

Prescriber's Name: _____

Specialty: _____ Phone: _____ Fax: _____

Contact Name: _____

Patient Information

Name: _____ CHP Member ID: _____

DOB _____ Age _____ Sex: Female Male

Does the patient have one of the following?

Diabetes _____ Immunocompromising disease: _____ (Please explain): _____

Ambulation impairment _____

Involvement that impairs daily activities _____

Please describe:

Area of infection: Fingernails _____ Toenails _____

Medication requested: Itraconazole (Sporanox[®]) _____ Terbinafine (Lamisil[®]) _____

Other Information:

Requesting prescriber's signature: _____

Coverage policy: Community Health Plan will cover the cost of treatment of Onychomycosis for those members who demonstrate disease involvement that impairs ambulation or normal daily activities **or** if the member is greater than 60 years of age **or** has diabetes **or** is immunocompromised. Coverage will be for six weeks (fingernails) or 12 weeks (toenails) per 12 months.

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