DIVISION OF HEALTH CARE FINANCING AND POLICY

NEVADA MEDICAID

DRUG USE REVIEW (DUR) BOARD

PROPOSED PRIOR AUTHORIZATION CRITERIA

Generic Name: Terbinafine, Itraconazole, Ciclopirox

Brand Name: Lamisil®, Sporanox®, Penlac®

Medication Class: Anti-Fungal Agents

1. Coverage and Limitations

Criteria for Approval:

I. Anti-Fungal **Onychomycosis** (Lamisil®, Sporanox®, Penlac®)

Anti-Fungal **Onychomycosis** are a covered benefit for recipients who meet the criteria for coverage.

1. Coverage and Limitations:

Authorization will be given if the following criteria are met and documented:

a. Do not authorize itraconazole if recipient has evidence of ventricular dysfunction;

b. Do not authorize terbinafine if recipient has pre-existing liver disease;

c. Positive KOH stain, positive PAS stain or positive fungal culture and any of the following:

1. Recipient experiencing pain which limits normal activity
2. Recipient has an iatrogenically-induced or disease associated immunosuppression
3. Recipient has diabetes
4. Recipient has significant peripheral vascular compromise

d. Length of Authorization:

1. Lamisil® *Tablet* & Sporanox *Tablet* ®

Fingernail: 6 weeks

Toenail: 12 weeks

2. Penlac® *Liquids*
Initial: 3 months
Follow-up: 3 months (Up to 12 months)

2. PA Guidelines:
PA Form: Generic Nevada Medicaid Request for Prior Authorization Form