BlueCross BlueShield of Arizona
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PHARMACY COVERAGE GUIDELINES	
SECTION: DRUGS	
ORIGINAL EFFECTIVE DATE:	**11/20/14**
LAST REVIEW DATE:	**11/15/18**
LAST CRITERIA REVISION DATE:	**11/15/18**
ARCHIVE DATE:	

JUBLIA® (efinaconazole) topical solution, 10%
KERYDIN™ (tavaborole) topical solution, 5%

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

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KERYDIN™ (tavaborole) topical solution, 5% (cont.)

Criteria:

- **Criteria for initial therapy:** Jublia (efinaconazole) or Kerydin (tavaborole) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Age of the individual is:
     - **For Jublia:** 18 years of age or older
     - **For Kerydin:** 12 years of age or older

  2. A confirmed diagnosis of onychomycosis of toenail(s) due to **EITHER** *Trichophyton rubrum* or *Trichophyton mentagrophytes* as the causative organism
     - Confirmed diagnosis using both of the following:
       - Positive potassium hydroxide (KOH) on microscopy
       - Positive fungal culture

  3. Failure, contraindication or intolerance to **BOTH**:
     - Terbinafine
     - Itraconazole

  Initial approval duration: 12 months

- **Criteria for continuation of coverage (renewal request):** Jublia (efinaconazole) or Kerydin (tavaborole) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual experienced a recurrent episode (a relapse or reinfection) of symptomatic confirmed diagnosis of onychomycosis of toenail(s) due to **EITHER** *Trichophyton rubrum* or *Trichophyton mentagrophytes* as the causative organism
     - Confirmed diagnosis using both of the following:
       - Positive potassium hydroxide (KOH) on microscopy
       - Positive fungal culture

  2. The indication for use is one that requires a longer duration than the usual duration and the other alternatives as listed in the criteria for initial therapy section cannot be used

  3. Individual has been adherent with the medication

  Renewal duration: 12 months

Description:

Jublia (efinaconazole) topical solution is an azole (triazole class) antifungal agent indicated for the treatment of onychomycosis of the toenails due to *Trichophyton rubrum* and *Trichophyton mentagrophytes*. Kerydin

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(tavaborole) topical solution is an oxaborole antifungal agent indicated for the treatment of onychomycosis of the toenails due to *Trichophyton rubrum* and *Trichophyton mentagrophytes*.

Jublia (efinaconazole) inhibits fungal lanosterol 14-alpha demethylase that is involved in the biosynthesis of ergosterol, an integral component of fungal cell membrane. Safety and effectiveness in pediatric individuals has not been established.

Kerydin (tavaborole) inhibits fungal protein synthesis by inhibiting aminoacyl-transfer ribonucleaic acid (tRNA) synthestase (AARS). Safety and effectiveness in pediatric individuals has not been established.

Coverage is dependent on individual member plan benefit.

Onychomycosis:

- Onychomycosis is a common dermatological condition
- It is an infection of the nail apparatus caused by fungi that include dermatophytes, non-dermatophyte molds and yeasts (mostly Candida species)
- The toenails are affected in 80% of cases
    - Dermatophyte infection due to *Trichophyton rubrum* and/or *Trichophyton mentagrophytes* are the cause in over 90% of cases
- Onychomycosis is characterized by thickening of the distal end of the nail associated with some loosening or separation of the nail plate from the nail bed (onycholysis), and buildup of debris in the space created by the onycholysis (subungual hyperkeratosis)
    - The nail plate turns yellow and vertical bands appear at the distal end of the nails
    - These foot infections are not life-threatening but it may cause discomfort and pain
- Onychomycosis may be classified clinically as:
    - Distal and lateral subungual onychomycosis (DLSO)
        - Accounts for the majority of cases and is almost always due to dermatophyte infection
    - Superficial white onychomycosis (SWO)
        - Nearly always due to a dermatophyte infection, most commonly *Tricophyton mentagrophytes*
        - It is much less common than DLSO
    - Proximal subungual onychomycosis (PSO)
    - Candidal onychomycosis
    - Total dystrophic onychomycosis
    - Any of these may eventually progress to total nail dystrophy where the nail plate is almost completely destroyed
    - Only about 50% of nail dystrophy cases are caused by fungi making it important to establish the cause to rule out other conditions with similar presentations such as psoriasis and nail trauma
    - Despite this most onychomycosis is treated based on clinical presentation alone
    - Treatment should be initiated only with mycological confirmation of infection

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- Laboratory diagnosis consists of direct microscopy to visualize fungal elements in the nail sample and culture to identify the species

- Approaches to treatment:
  - The relative efficacy of different antifungal agents against different fungi is not completely understood and is poorly described due to use of different doses and dose scheduling, differing endpoints in the clinical studies, length of treatment, and lack of active comparisons
  - A common surrogate measure of efficacy is mycologic cure rate defined as having negative potassium hydroxide (KOH) on microscopy and negative fungal culture
  - Another measure used to assess efficacy is complete cure which is defined as no clinical involvement of the target nail or a mycologic cure defined as negative KOH and negative culture
  - Mycologic cure rates are numerically better than clinical cure rates and as a result may overemphasize efficacy of treatment
  - The goal of treatment is to eradicate the causative organism as demonstrated by microscopy and culture
  - All treatments for onychomycosis have relatively high failure rates
  - Recurrence rates range from approximately 20-50%

- Treatment options:
  - Topical and oral agents are available for the treatment of fungal nail infections
  - Treatment duration with these agents is usually months
  - There are no clinical trials that compare oral antifungal agents to topical agents
    - However, oral agents appear to achieve higher mycological cures than those seen with topical agents
    - A meta-analysis of onychomycosis treatments found the risk of severe liver injury or asymptomatic elevations of serum transaminases with all agents to be less than 2%
  - Topical antifungal preparations available both as prescription only medicines and over-the-counter products
  - Topical therapy may be useful for the treatment of SWO and in very early cases of DLSO where the infection may be confined to the distal edge of the nail
  - Systemic therapy is more successful than topical treatment
  - Agents used to treat onychomycosis include:
    - Oral Terbinafine
      - The most effective agent and is considered first line treatment
      - When used continuously the mycologic cure rate is 76%
      - When used intermittently the mycologic cure rate is 59%
    - Oral Itraconazole
      - Is recommended when Terbinafine cannot be used due to failure or intolerance
      - It has a mycologic cure rate of 63% with pulse dosing and 59% with continuous dosing
    - Oral Fluconazole (for Candida species)
    - Topical Jublia (efinaconazole)
      - The absolute mycologic cure rate for Jublia is 36.5-38.4% (Jublia package insert)
    - Topical Kerydin (tavaborole)

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- The absolute mycologic cure rate for Kerydin is 23.7-23.9 (Kerydin package insert)

- Topical Ciclopirox nail lacquer
  - The absolute mycologic cure rate for topical Ciclopirox is 18-27% (package insert Penlac)

Resources:

Jublia. Package Insert. Reference ID 3519795. Revised by manufacturer 06/2014. Accessed 10-23-2014.

Kerydin. Package Insert. Reference ID 3537640. Revised by manufacturer 07/2014. Accessed 11-05-2014.

Roberts, DT, Taylor WD, Boyle J. Guidelines for treatment of onychomychosis. Br J Dermatol 2003; 148:402-410

Chang CH, Young-Xu Y, Kurth T, et al.: The safety of oral antifungal treatments for superficial dermatophytosis and onychomycosis: A meta-analysis. Am J Med 2007; 120 (9):791-798

Lamisil. Package insert. Reference ID 3395056. Revised by manufacturer 10/2013. Accessed on 11-05-2014

Sporanox. Package insert. Reference ID 3520611. Revised by manufacturer 06/2014. Accessed on 11-05-2014

Jublia. Package Insert. Revised by manufacturer 02/2015. Accessed 10-13-2015.

Kerydin. Package Insert. Revised by manufacturer 03/2015. Accessed 10-13-2015, 09-28-2016

Jublia. Package Insert. Revised by manufacturer 05/2016. Accessed 09-28-2016.

UpToDate: Onychomycosis: Epidemiology, clinical features, and diagnosis. Current through Sep 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/onychomycosis-epidemiology-clinical-features-and-diagnosis?source=search_result&search=onychomycosis&selectedTitle=2~82#H30

UpToDate: Onychomycosis: Management. Current through Sep 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/onychomycosis-management?source=search_result&search=onychomycosis&selectedTitle=1~82

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:		Dosage Form:
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. **What is the diagnosis? Please specify below.**

   ICD-10 Code: _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. **Are there any supporting labs or test results? Please specify below.**

Date	Test	Value

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6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.