



Date of Request \_\_\_\_\_

**PENLAC - ciclopirox**

**Member Information**

Name \_\_\_\_\_  
Enrollment / Cardholder ID \_\_\_\_\_  
Group / Plan \_\_\_\_\_  
Birth Date \_\_\_\_\_  
Address \_\_\_\_\_  
City State Zip \_\_\_\_\_

**Relationship (Circle)**

Subscriber      Spouse      Dependent  
**Gender (Circle)**  
Male                      Female  
**AGE:** \_\_\_\_\_

**Practitioner Information**

Name \_\_\_\_\_  
Agent / Contact Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
Office / Clinic Name \_\_\_\_\_  
Address \_\_\_\_\_  
City State Zip \_\_\_\_\_  
Phone (      ) - \_\_\_\_\_  
Fax (      ) - \_\_\_\_\_  
Email \_\_\_\_\_@\_\_\_\_\_

**Primary Diagnosis Condition /  
Diagnosis Related – Reason for Request**

- Does the patient have documented onychomycosis? **Y / N**
- Please indicate severity:  Mild     Moderate     Severe
- Is there Lunula involvement? **Y / N**
- Does the patient experience pain on mobilization? **Y / N**
- Is the patient undergoing a comprehensive management program for the treatment of the onychomycosis? Please define:  
\_\_\_\_\_  
\_\_\_\_\_
- Were the unattached, infected nails removed? **Y / N**
- Does the patient have a documented contraindication to oral therapies? **Y / N**
- If yes, please define: \_\_\_\_\_

**Strength / Dose**

\_\_\_\_\_

**Duration of Therapy (Expected)**

\_\_\_\_\_

**Formulary Alternatives  
Attempted/Outcome**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Clinical Drug / Lab History Pertinent to Request**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Contact Pharmacy?                      Y                      N**  
**Pharmacy Phone Number**

\_\_\_\_\_

**Practitioner Signature**

Date Received: \_\_\_\_\_  
Reviewed By: \_\_\_\_\_  
Forwarded To: \_\_\_\_\_

**FAX Form to  
877-800-5633**