JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Pharmacy Public** **Pharmacy Management Drug Policies**	*Policy Number*	MEDS088
		Effective Date	01/21/2015
		Review Date	01/21/2015
	Subject **Topical Antifungal-Jublia, Kerydin**	*Revision Date*	12/15/2020
		Page	1 of 2

This document applies to the following Participating Organizations:

Priority Partners

Keywords: antifungal, Jublia, Kerydin

Table of Contents		Page Number
I.	POLICY	1
II.	POLICY CRITERIA	1
	A. Jublia	1
	B. Kerydin	1
III.	AUTHORIZATION PERIOD/LIMITATIONS	1
IV.	EXCLUSIONS	1
V.	REFERENCES	1
VI.	APPROVALS	2

I. POLICY

A. Topical antifungals Jublia (efinaconazole) and Kerydin (tavaborole) will require prior authorization to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.
   1. PPMCO members are subject to the Priority Partners formulary, available at www.ppmco.org.
   2. USFHP members are subject to prior authorization criteria, step-edits and days-supply limits outlined in the Tricare Policy Manual. Tricare Policy supersedes JHHC Medical/Pharmacy Policies. Tricare limits may be accessed at: http://pec.ha.osd.mil/formulary_search.php?submenuheader=1

II. POLICY CRITERIA

A. **Jublia** or **Kerydin** may be approved for patients meeting the following:
   1. Documented diagnosis of onychomycosis of the toenail
   2. Documentation showing a positive KOH test
   3. Documentation showing both of the following:
      a. Trial and inadequate response to two formulary medications (terbinafine, itraconazole, griseofulvin, or fluconazole), or a contraindication to all of these oral medications
      b. Trial and inadequate response to ciclopirox topical solution 8%

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Jublia or Kerydin will be approved for 48 weeks of therapy.

IV. EXCLUSIONS

A. Jublia and Kerydin will not be covered for the following:
   1. Patients with a known adverse reaction to Jublia or Kerydin

B. The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

V. REFERENCES

1. Johns Hopkins HealthCare Pharmacy Policy PHARM20, Step Therapy, Prior Authorization and Quantity Limits

2. Kerydin (Tavaborole) [Prescribing information]. Palo Alto, CA: Anacor Pharmaceuticals; 2014 July.
3. Jublia (efinaconazole) [Prescribing information]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; 2014 June.
4. Goldstein, A. (2014). Onychomycosis. In R.P. Dellavalle (Ed.), *Up to Date* (pp. xx–xx). Retrieved from http://www.uptodate.com/contents/onychomycosis?source=machineLearning&search=onychomycosis+treatment&selectedTitle=1~40§ionRank=1&anchor=H15#H15

VI. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
07/27/2017	Updated Exclusions section regarding physician samples
07/01/2018	Removed EHP Line of Business
12/15/2020	Updated criteria layout

Review Dates: 01/21/2015

Revision Dates: 07/27/2017, 07/01/2018, 12/15/2020