



Montana Healthcare Programs  
Drug Prior Authorization Coverage Criteria

Efudex™ (fluorouracil cream)

**Review Criteria**

Member must meet all the following criteria:

- Subject to Preferred Drug List requirements
- Member must have a diagnosis of Actinic Keratosis or basal cell carcinoma
- Can also be requested for the treatment of viral warts IF member has tried and failed other modalities of wart treatments