



Montana Healthcare Programs
Drug Prior Authorization Coverage Criteria

Kerydin™ (tavaborole topical solution)

Review Criteria

Member must meet all the following criteria:

- Subject to Preferred Drug List requirements
- Must have diagnosis of onychomycosis of toenails
- Member must be ≥18 years of age.
- Documented major clinical complication secondary to onychomycosis (i.e., impaired functioning, secondary bacterial infection, etc.)
 - Not covered for cosmetic reasons
- Must have contraindication to oral terbinafine (i.e., severe hepatic disease, previous adverse reaction to terbinafine)

Limitations:

- Maximum quantity allowed per month is 4mLs
- Maximum length of treatment is 48 weeks