HIGHMARK HEALTH OPTIONS

Updated: 07/2024
Approved: 07/2024

Request for Prior Authorization for Ycanth (cantharidin)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Ycanth (cantharidin) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Ycanth (cantharidin) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of **molluscum contagiosum** and the following criteria is met:

- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- The requested dose and frequency are in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must be prescribed by or in consultation with a dermatologist.
- Documentation of ONE of the following:
    - Itching, pain, or bleeding associated with lesions
    - Member is immunocompromised
    - Concomitant bacterial infection
    - Risk of spread (i.e. sibling, daycare, etc.)
- Documentation of ONE of the following:
    - Member is treating new lesions that have not previously been treated with Ycanth (cantharidin)
    - Lesions have previously been treated with Ycanth (cantharidin) and will not exceed a total of 4 treatments with Ycanth (cantharidin)
- Documentation the member has tried and failed or had an intolerance or contraindication to ONE of the following:
    - Podofilox
    - Cryotherapy
    - Curettage
    - Laser therapy.
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Documentation of ALL of the following:
        - the member has shown improvement from treatment demonstrated by a reduction in the size or number of lesions
        - at least 3 weeks have passed since the previous application
        - total duration of therapy has not exceeded 4 applications
- **Reauthorization Duration of Approval:** 6 months.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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YCANTH (CANTHARIDIN)
PRIOR AUTHORIZATION FORM – PAGE 1 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION	
Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION		
Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION		
Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information
This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information	
Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)	
Diagnosis:	ICD Code:

Is the member experiencing any of the following? (*please mark all that apply)*
☐ Itching, pain, or bleeding associated with lesions
☐ Is immunocompromised
☐ Has a concomitant bacterial infection
☐ There is a risk of spread (i.e. siblings, daycare, etc.)

Is the request for new lesions that have not previously been treated? ☐ Yes ☐ No

Have the lesions previously been treated with Ycanth (cantharidin)? ☐ Yes ☐ No
If yes how many times and when? _____

Has the member tried any of the following? (*please mark all that apply)*
☐ podofilox
☐ cryotherapy
☐ curettage
☐ laser therapy

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

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YCANTH (CANTHARIDIN)
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REAUTHORIZATION

Has the member experienced a significant improvement with treatment demonstrated by a reduction in the size or number of lesions?
☐ Yes ☐ No

Has at least 3 weeks passed since the previous application?
☐ Yes ☐ No

How many applications has the member had in the past? _____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date