



Updated: 09/2025
Approved: 09/2025

**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.

**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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Billing Information

This medication will be billed: <input type="checkbox"/> at a pharmacy OR <input type="checkbox"/> medically, JCODE:	
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> 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? <i>(please mark all that apply)</i>	
<input type="checkbox"/> Itching, pain, or bleeding associated with lesions <input type="checkbox"/> Is immunocompromised <input type="checkbox"/> Has a concomitant bacterial infection <input type="checkbox"/> There is a risk of spread (i.e. siblings, daycare, etc.)	
Is the request for new lesions that have not previously been treated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have the lesions previously been treated with Ycanth (cantharidin)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes how many times and when? _____	
Has the member tried any of the following? <i>(please mark all that apply)</i>	
<input type="checkbox"/> podofilox <input type="checkbox"/> cryotherapy <input type="checkbox"/> curettage <input type="checkbox"/> 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.**

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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

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