Prior Authorization Form

Lamisil

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Lamisil.

Drug Name (select from list of drugs shown)

Lamisil Tablet (terbinafine) Terbinafine Tablets

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for the treatment of onychomycosis due to dermatophytes (tinea unguium) confirmed by a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture or nail biopsy)?	Y N
[If yes, then no further questions.]	
2. Is the requested drug being prescribed for the treatment of tinea capitis?	Y N
[If yes, then no further questions.]	

3.	Is the requested drug being prescribed for the treatment of tinea corporis or tinea cruris?	Y N
4.	Does the patient have any of the following: A) extensive disease, B) dermatophyte folliculitis is present, C) did not respond to topical therapy, D) is immunocompromised?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date