



Prescription Drug Coverage Determination Form
Antifungal
Lamisil® (terbinafine)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-647-2240.

Patient Information

Patient Name: Date of Birth:
Subscriber ID#:
Address City State Zip Code

Physician Information

Name: Specialty: Tax ID#:
Office Address City State Zip Code
Telephone: Fax: Contact Person

Physician Signature (REQUIRED): Date

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: J-code:
Dose: Directions:
Expected Duration of Therapy:

Prior Authorization Criteria:

- 1. Does the patient have a diagnosis of a FDA approved indication not otherwise excluded from Part D?
2. Has the diagnosis been confirmed with a fungal diagnostic test (KOH preparation, fungal culture, or nail biopsy)?
3. Is the infection limited to the fingernails?
4. Does the infection involve the toenails or toenails and fingernails?
5. Has the patient received treatment with oral Lamisil® in the past 12 months?
6. Will the liver function test (LFTs) be monitored prior to initiation and as needed during Lamisil® therapy?

Please provide any additional history or medical information that may support coverage (attach office notes as necessary):

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.