



Prescription Drug Coverage Determination Form
Antifungal
Lamisil® (terbinafine)

Please fax the completed form to Mercy Health Plans' Pharmacy Department
at 314-214-8201 or 1-800-466-9854.

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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diagnosis: _____ ICD-9: _____ Date of Diagnosis: _____ | | |
| 2. Has the diagnosis been confirmed with a fungal diagnostic test (KOH preparation, fungal culture, or nail biopsy)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Results: _____ | | |
| 3. Is the patient immunocompromised? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Does the patient have a diagnosis of diabetes mellitus? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Does the patient have a diagnosis of peripheral vascular disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Does the patient have redness and swelling in the surrounding tissue? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Is the infection limited to the fingernails? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Does the infection involve the toenails or toenails and fingernails? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Has the patient received treatment with oral Lamisil® in the past 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Will the liver function test (LFTs) be monitored prior to initiation and as needed during Lamisil® therapy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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.