



Lamisil® (terbinafine) Prior Authorization Request Form

Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-466-9854. For additional information please call 314-214-8282 or 800-647-2240.

Patient Name: Today's Date:
Patient Pharmacy ID: Date of Birth:
Requesting Physician: Specialty:
Office Contact Person: Phone #:
Office Address:
Medication/dose Requested: Fax #:
Expected Duration of Therapy: ICD-9

INITIAL AUTHORIZATION REQUEST:
1. Does the patient have a diagnosis of onychomycosis? YES NO
2. Has the diagnosis been confirmed with a fungal diagnostic test (KOH or fungal culture)? YES NO
Results:
3. Is the patient immunocompromised? YES NO
4. Does the patient have any of the following? (mark all that apply) YES NO
Diabetes mellitus
Peripheral vascular disease
5. Does the patient have pain, swelling or redness in the surrounding tissue? YES NO
6. Area of the body affected
Fingernails only
Toenails only
Both fingernails and toenails
RENEWAL AUTHORIZATION REQUEST:
1. Does the patient have a diagnosis of onychomycosis? YES NO
2. Has the patient received at least 2 months of therapy for a fingernail infection or 3 months for a toenail infection? YES NO
3. Has the patient had a documented response to therapy? YES NO
4. Has the patient received the maximum duration of therapy within the previous year? YES NO
(The maximum for fingernails is 3 months; toenails is 4 months; and if both affected 4 months.)

Physician's Signature: Date:

For Mercy Health Plans use only:
Approved Length of Approval
Denied Reason for Denial
Reviewer's Signature: Date Reviewed:
Override Entered in Caremark CCMS for - by
Office Notified on ; at am/pm; by spoke to