



Lamisil® (terbinafine) Prior Authorization Request Form

Please fax the completed request form to the Coventry Health Care Pharmacy Department at 877-815-8751. For additional information please call 800-647-2240.

Patient Name: _____ Today's Date: ____/____/____
 Patient Pharmacy ID: _____ Date of Birth: ____/____/____
(located on bottom right of insurance card)
 Requesting Physician: _____ Specialty: _____
(Please print)
 Office Contact Person: _____ Phone #: (____)____-____ ext ____
 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 |
| <input type="checkbox"/> Diabetes mellitus | | |
| <input type="checkbox"/> Peripheral vascular disease | | |
| 5. Does the patient have pain, swelling or redness in the surrounding tissue? | YES | NO |
| 6. Area of the body affected | | |
| <input type="checkbox"/> Fingernails only | | |
| <input type="checkbox"/> Toenails only | | |
| <input type="checkbox"/> 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?
(The maximum for fingernails is 3 months; toenails is 4 months; and if both affected 4 months.) | YES | NO |

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 _____