



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Terbinafine Tablets (Medicare Prior Auth)**

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 Terbinafine Tablets (Medicare Prior Auth).

Drug Name (select from list of drugs shown)
Terbinafine

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

1. Has the patient received treatment with oral Lamisil (terbinafine) in the past 12 months? Y N
 [If the answer to this question is yes, then no further questions required.]
2. Will the LFTs of the patient be checked prior to initiation of therapy and as needed during Lamisil therapy? Y N
3. Does the patient have the diagnosis of onychomycosis due to dermatophytes (tinea unguium)? Y N
 [If the answer to this question is no, then no further questions are required.]
4. Has the diagnosis been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)? Y N
5. Is the infection limited to the fingernails? Y N
 [If the answer to this question is yes, then no further questioned required.]
6. Does the infection involve the toenails or toenails and fingernails? Y N

Comments: _____



**Arkansas
BlueCross BlueShield**
An Independent Licensee of the Blue Cross and Blue Shield Association

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date