

TERBINAFINE TABLETS

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 1-888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

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

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6. Does the infection involve the toenails or toenails and fingernails?

Y	N
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Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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