

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
LAMISIL (terbinafine HCl)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES

TO 855-828-4992 note the new fax number

CRITERIA:

- Documented diagnosis of onychomycosis.
- Authorized for 16 weeks per calendar year.

RE-AUTHORIZATION:

Same process as initial PA.

9/15/10

<http://health.utah.gov/medicaid/pharmacy>