UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

LAMISIL (terbinafine HCl)

Patient name:______________________________Medicaid or SS#__________________________

Physician Name:_________________________ Contact person:______________________________

Phone#:____________________Ext. and options________________Fax#__________________

Pharmacy______________________________Pharmacy Phone#:____________________________

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

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FAX DOCUMENTATION FROM PROGRESS NOTES (801) 536-0477

CRITERIA:

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

RE-AUTHORIZATION:

Same process as initial PA.

2/2/07