MC-Rx
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Lamisil® terbinafine

Ticket #: _____ **Request Date:** _____ **Request Time:** _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Lamisil®** terbinafine. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information		
Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information			
Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

1.	Is patient at least 18 years of age (Lamisil Tabs) or 4 years of age or older (Lamisil Oral Granules)?	YES	NO
2.	Does patient have a current diagnosis of onychomycosis of the toenail or fingernail (Lamisil Tabs) or tinea capitis (Lamisil Granules)?	YES	NO
3.	Was the diagnosis confirmed by obtaining nail/scalp specimens for laboratory testing (e.g. KOH preparation, fungal culture or nail biopsy)?	YES	NO
4.	Does patient have renal function impairment?	YES	NO
5.	Does patient have hepatic function impairment?	YES	NO
6.	Have liver function tests [serum transaminase (ALT and AST) tests] been ordered for this patient prior to initiation of therapy with terbinafine? **Please provide copy of the lab results**.	YES	NO

FOR RE-CERTIFICATION ONLY:
While taking terbinafine, has patient had any of the following signs/symptoms: persistent nausea, anorexia, fatigue, vomiting, right upper abdominal pain or jaundice, dark urine, or pale stools? YES NO

Dosing Guidelines:

Lamisil Tabs (Patients ≥ 18 years old): ONYCHOMYCOSIS OF TOE NAILS: 250 mg PO QD x 12 weeks
ONYCHOMYCOSIS OF FINGERNAILS: 250 mg PO QD x 6 weeks

Lamisil Oral Granules (Patients > 4 years old): Take once a day with food for 6 weeks (dose based on body weight).

Dosing by Body Weight:

<25 kg	125 mg/day
25-35 kg	187.5 mg/day
>35 kg	250 mg/day

Authorized Medical Signature:

Telephone: **Date:**

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.