09/25/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN(MEDICAID)

Lamisil (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-844-242-0908**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Lamisil (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Lamisil (terbinafine)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

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

Prescribing Physician

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

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Does the patient have hypersensitivity to terbinafine or to any other ingredients of the formulation? Y N

   [If the answer to this question is yes, then no further questions required.]

2. Is terbinafine being requested for cosmetic use? Y N

   [If the answer to this question is yes, then no further questions required.]

3. Has the patient had a KOH Stain or culture supporting diagnosis of onychomycosis OR onychomycosis in the presence of one of the listed comorbidities listed below? Y N

   abetes (pharmacologically managed) \ HIV infection \ Immunosuppressed (patients receiving chemotherapy; continuous, long term oral steroids; continuous, long term azathioprine; agents for organ rejection) \ Peripheral vascular disease documented by Ankle Brachial Index (ABI) (e.g., Raynaud's, Buerger's, intermittent claudication, atherosclerosis, varicose veins, vasculitis)

   [If the answer to this question is no, then no further questions required.]

4. Does the patient have fingernail onychomycosis? Y N

   [If the answer to this question is yes, then skip to question 6.]

5. Does the patient have toenail onychomycosis? Y N

   [If the answer to this question is no, then no further questions required.]

6. Is this a renewal request? Y N

Comments:

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

Prescriber (Or Authorized) Signature Date