



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

TERBINAFINE

Coverage Criteria / Required Medical Information

FDA approved indication not otherwise excluded from Part D.
LFTs, fungal diagnostic test (e.g., KOH preparation, positive fungal culture, or nail biopsy).

Coverage Duration - 2 months for fingernails only, 3 months if toenail involvement, 6 weeks for Tinea infections

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

TERBINAFINE	Reason for Request	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage			
Formulary Alternative(s) Attempted?	Yes:		No:	
Please List Alternative Formulary Drugs				

Comments	
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Physicians Signature: _____ Fax Form to 1-866-481-3704