Prescriber Criteria Form Terbinafine 2026 PA Fax 6413-A v1 010126.docx Terbinafine tablets Prior Authorization applies to greater than cumulative 90 days of therapy per year. Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Terbinafine tablets.

Drug Name: Terbinafine tablets

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of onychomycosis of the toenail or fingernail due to dermatophytes (tinea unguium)? [If no, then no further questions.]	Yes	No
2	Will the patient be using the requested drug orally? [If no, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for non-continuous use?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____