

**Physician's Prior Authorization Questionnaire
Lamisil®**

Patient:

ID#:

DOB:

Patient Address:

Lamisil® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* _____

2. Please list previous medication(s) the patient tried that were not effective:

Medication	Dose	Duration of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. How long do you anticipate this treatment to last? _____

4. What other medication condition(s) does the patient currently have?

5. Has the patient been treated with Lamisil® for this indication before? Yes No

If Yes, was it effective? Yes No

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx