PRIOR AUTHORIZATION CRITERIA

<table>
<thead>
<tr>
<th>BRAND NAME (generic)</th>
<th>LAMISIL ORAL GRANULES (terbinafine)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status: CVS Caremark Criteria</td>
<td></td>
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<tr>
<td>Type: Initial Prior Authorization</td>
<td></td>
</tr>
</tbody>
</table>

POLICY

FDA-APPROVED INDICATIONS
Lamisil (terbinafine hydrochloride) Oral Granules are indicated for the treatment of tinea capitis in patients 4 years of age and older.

COVERAGE CRITERIA
Lamisil Granules will be covered with prior authorization when the following criteria are met:
- The requested drug is being prescribed for the treatment of tinea capitis in a patient 4 years of age or older

REFERENCES