pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTIVIRALS, ORAL PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antivirals, Oral** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:

☐Famvir tablet	☐rimantadine tablet	☐**Tamiflu suspension****	☐Zovirax suspension
☐**oseltamivir capsule****	☐Sitavig buccal tablet	☐Valtrex tablet	☐Zovirax tablet
☐**oseltamivir suspension****	☐**Tamiflu capsule****	☐Zovirax capsule	☐_____

****Note:** **Tamiflu and oseltamivir products are PREFERRED but may require review for quantity limits prior authorization based on dose and duration of therapy.**

Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Requests for TAMIFLU / OSELTAMIVIR QUANTITY LIMITS

1. Prior authorization of preferred **Tamiflu/oseltamivir** requires review for quantity limits prior authorization when one of the following applies. *Submit documentation supporting the beneficiary's need for extended or repeated therapy.*
   - ☐when prescribed for once daily administration for influenza prophylaxis, more than 21 days of therapy in the past 6 months
   - ☐when prescribed for twice daily administration for influenza treatment, more than 10 days of therapy in the past 6 months

Non-Preferred Requests for an INFLUENZA Diagnosis

2. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Antivirals, Oral Agents for the treatment of influenza?
   - ☐Relenza Diskhaler
   - ☐Tamiflu/oseltamivir suspension/capsule

   ☐Yes – *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*
   ☐No

Non-Preferred Requests for a Non-Influenza Diagnosis

3. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Antivirals, Oral Agents? *Check all that apply.*
   - ☐acyclovir capsule, tablet, or suspension
   - ☐famciclovir tablet
   - ☐valacyclovir tablet

   ☐Yes – *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*
   ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: