

ANTIVIRALS, ORAL PRIORITY AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Oral Antiviral Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antivirals, Oral** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to Quantity Limits list at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> 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#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:	<input type="checkbox"/> Famvir tablet <input type="checkbox"/> Sitavig buccal tablet <input type="checkbox"/> Tamiflu capsule/suspension (*preferred with quantity/duration limit*) <input type="checkbox"/> Valtrex tablet	<input type="checkbox"/> Zovirax capsule <input type="checkbox"/> Zovirax suspension <input type="checkbox"/> Zovirax tablet	
Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		DX code (<i>required</i>):	

Requests for TAMIFLU for MORE THAN a 5-DAY treatment course

1. Does the recipient require therapy at the prescribed dose for more than 5 days?	<input type="checkbox"/> Yes – <u>Submit supporting documentation.</u> <input type="checkbox"/> No
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Non-Preferred Requests

2. Does the recipient have a history of trial and failure, contraindication, or intolerance of the preferred Oral Antiviral Agents? <i>Check all that apply.</i> <input type="checkbox"/> acyclovir capsule, tablet, or suspension <input type="checkbox"/> famciclovir tablet <input type="checkbox"/> valacyclovir tablet	<input type="checkbox"/> Yes – <u>Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.</u> <input type="checkbox"/> No
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PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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