

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Antivirals, Topical

A. Prescriptions That Require Prior Authorization

All prescriptions for non-preferred Antivirals, Topical must be prior authorized. See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred Antivirals, Topical.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Antiviral, Topical, the determination of whether the requested prescription is medically necessary will take into account the following:

1. Whether the recipient has a documented history of therapeutic failure or intolerance of the preferred Antivirals, Topical;

OR

2. Whether the recipient does not meet the clinical review guidelines listed in B.1. above, but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. 1. above, to assess the medical necessity of the request for a prescription for a non-preferred Antiviral, Topical. If the guidelines in Section B. 1. are met, the reviewer will prior authorize the prescription. If either of the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.