

Clinical Policy: Antivirals, Influenza

Reference Number: PHW.PDL.736

Effective Date: 01/01/2020

Last Review Date: 10/2021

[Revision Log](#)

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with PA Health and Wellness® that Antivirals, Influenza are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antivirals, Influenza

A. Prescriptions That Require Prior Authorization

Prescriptions for Antivirals, Influenza that meet any of the following conditions must be prior authorized:

1. A non-preferred Antiviral, Influenza.
2. An Antiviral, Influenza with a prescribed quantity that exceeds the quantity limit.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antiviral, Influenza, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Antiviral, Influenza, has a history of intolerance or contraindication of the preferred Antivirals, Influenza; **AND**
2. If a prescription for an Antiviral, Influenza is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of the request for a prescription for an Antiviral, Influenza. If the guidelines in Section B. are met, the

reviewer will prior authorize the prescription. If 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 beneficiary.

D. Approval Duration: 6 months

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022 annual review: no changes.	10/2021