

## Clinical Policy: Antivirals, Herpes

Reference Number: PHW.PDL.123

Effective Date: 01/01/2020

Last Review Date: 11/2025

### 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 PA Health & Wellness® that Antivirals, Herpes are **medically necessary** when the following criteria are met:

### I. Requirements for Prior Authorization of Antivirals, Herpes

#### A. Prescriptions That Require Prior Authorization

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

1. A non-preferred Antiviral, Herpes.
2. An Antiviral, Herpes 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, Herpes, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. For a non-preferred Antiviral, Herpes, has a history of therapeutic failure, intolerance, or contraindication of the preferred Antivirals, Herpes approved for the member's diagnosis or indication; **AND**
2. If a prescription for an Antiviral, Herpes 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 member 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 member, 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 a prescription

for an Antiviral, Herpes. 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 member.

**D. Approval Duration: 6 months**

<b>Reviews, Revisions, and Approvals</b>	<b>Date</b>
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.	11/2021
Q1 2023 annual review: no changes	11/2022
Q1 2024 annual review: no changes	11/2023
Q1 2025 annual review: no changes	11/2024
Q1 2026 annual review: no changes	11/2025