GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
ANTIVIRALS, ORAL PA SUMMARY

Preferred	Non-Preferred
Acyclovir capsules, suspension, tablets generic Amantadine generic Famciclovir generic Oseltamivir generic Relenza (zanamivir) Valacyclovir generic	Rimantadine generic* Sitavig (acyclovir buccal) Xofluza (baloxavir)

*non-preferred but does not require PA

LENGTH OF AUTHORIZATION: Varies

NOTE: Rimantadine is non-preferred but does not require prior authorization.

PA CRITERIA:

Sitavig

- For immunocompetent members 18 years of age and older with a diagnosis of recurrent herpes labialis, prescriber must submit a written letter of medical necessity stating the reasons the preferred products, oral acyclovir, famciclovir, valacyclovir and Zovirax 5% cream, are not appropriate for the member.

Xofluza

- Approvable for members 5 years of age or older when used for the treatment of acute uncomplicated influenza who have been symptomatic for no more than 48 hours and have known or suspected resistance to or allergy, contraindication, drug-drug interaction or intolerable side effect to oseltamivir (Tamiflu).
- Approvable for members 12 years of age or older when used for the treatment of acute uncomplicated influenza who are high risk of developing influenza-related complications and have been symptomatic for no more than 48 hours and have known or suspected resistance to or allergy, contraindication, drug-drug interaction or intolerable side effect to oseltamivir (Tamiflu).
- Approvable for members 5 years of age or older when used for the prevention (prophylaxis) of acute uncomplicated influenza who have been living for at least 48 hours with an individual who has influenza and has been symptomatic for no more than 48 hours and have known or suspected resistance to or allergy, contraindication, drug-drug interaction or intolerable side effect to oseltamivir (Tamiflu).

QLL CRITERIA:

Medication	QLL
Valacyclovir tablets	30 tablets per 30 days

Valacyclovir

- An authorization to exceed the QLL may be granted for the following conditions: prevention of cytomegalovirus (CMV) disease following solid organ, bone marrow, or stem cell transplantation; suppressive therapy of recurrent genital herpes in members with HIV infection; or prevention of CMV disease in members with HIV infection.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.