Date ____________________

Client ____________________

PRIOR AUTH CRITERIA- ANTI-VIRALS (ANTI-HERPES)

M.D. Last Name: ________________________ ***M.D. First Name:*** ________________________

Physician Phone: ________________________ ***Physician Fax:*** ________________________

Patient ____________________________ ***ID#*** ____________________ ***DOB*** ______________

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please indicate which agent is being requested:

STEP B*
- ○ Valtrex

STEP C
- ○ Branded Zovirax
- ○ Branded Famvir

***Please note that if member is beginning therapy with an Anti-Viral Agent, the member's benefit will only cover generic acyclovir/famciclovir, unless the member has already tried and failed generic acyclovir and generic famciclovir**

2. For Step B Coverage ONLY: Has the patient tried and failed a 30-day trial of generic acyclovir? Yes No

3. For Step B Coverage ONLY: Has the patient tried and failed a 30-day trial of generic famciclovir? Yes No

4. Please explain the reason for failure or non-trial of generic acyclovir/famciclovir, and attach notes from the patient's chart as documentation.

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5. **Valtrex/Zovirax Only**-Does the patient have a known hypersensitivity or intolerance to valacyclovir, acyclovir, or any component of the formulation?

Yes No

6. **Famvir Only**-Does the patient have a known hypersensitivity to the product, its components, or penciclovir cream?

Yes No

Physician Signature or name of person providing answers ____

Physician Comments ____

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Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND. WI 53095

QUESTIONS PLEASE CALL:
877-526-9906