



Rational Drug Therapy Program
West Virginia University School of Pharmacy
On Behalf of the WV Bureau for Medical Services
PO Box 9511 HSCN
Morgantown WV 26506-9511

Requests for Exemption from Criteria
(Please print or type)
FAX, Phone, Mail completed form to:
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Neuraminidase Inhibitor Prior Approval Form

Patient Name _____ Medicaid ID # _____

Medication Name: _____ Dose: _____

Physician Name: _____ Return Fax Number: _____

Date of Request: _____

WV Bureau for Medical Services Policy:

Prescriptions for neuraminidase inhibitors require prior authorization. However, amantadine and ramantadine will not require prior authorization. Should *epidemic influenza B* be found in the larger communities in West Virginia, as reported by the Bureau for Public Health, prior authorization would not longer be required. The following prior approval criteria have been established:

1. Coverage is limited to treatment of influenza, not prevention.
2. Patient must have documented influenza type B, or there must be a documented influenza type B outbreak in the patient's community.
3. Patient must not be symptomatic for greater than 48 hours.

Prior Approval Request Information Needed:

Date of patient's onset of symptoms: _____

Does this patient have Influenza Type B? _____

What test was used to differentiate
between Influenza Type A and Influenza Type B? _____

I hereby certify, in writing, that the above name patient has influenza type B and it is clearly documented in the patient's medical chart.

(Physician's Signature)