Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial Individual (Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Prevymis® (letermovir)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Prevymis 240mg tablet
- ☐ Prevymis 480mg tablet
- ☐ Prevymis 240mg IV solution
- ☐ Prevymis 480mg IV solution

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

Place of administration:
- ☐ Self-administered
- ☐ Physician's office
- ☐ Outpatient infusion
  Facility: _____ NPI:_____ Fax:_____
- ☐ Home infusion
  Facility: _____ NPI:_____ Fax:_____

Billing:
- ☐ Patient to fill at community pharmacy
- ☐ Physician to buy and bill
- ☐ Facility to buy and bill
- ☐ Specialty Pharmacy
  Pharmacy:_____ NPI:_____ Fax:_____

ICD code(s): _____

Drug cost information

The wholesale acquisition cost for Prevymis is $234 per tablet (240mg and 480mg). The total cost of therapy with this drug is approximately $23,400 per 100 days of therapy.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 03/2018
Last reviewed 03/2018

Precertification Requirements

Before this drug is covered, the patient must meet all of the following criteria:

1. Member is receiving Prevymis for the **prophylaxis** of cytomegalovirus (CMV) infection and disease in CMV-seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT)
   Note: Prevymis is not indicated for the treatment of CMV infection or prevention of CMV disease in other types of transplants.
2. Member is over the age of 18 years.
3. Not being used in combination with another antiviral agent for CMV.

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Prophylaxis of cytomegalovirus (CMV) infection and disease in CMV-seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT

☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Was a culture completed? ☐ Yes ☐ No

Note: Must have documented seroposivity for CMV within 1 year before HSCT (fax results with this request)

C. Is the member over the age of 18 years of Age? ☐ Yes ☐ No

Additional information
Notes:

1. If approved, authorization is for a maximum of 100 days.
2. Contraindicated with pimozide or ergot alkaloids. Additionally, letermovir must not be taken with pitavastatin/simvastatin when co-administered with cyclosporine.
3. If clinically significant CMV infection (defined as CMV disease or CMV viremia leading to preemptive treatment) develops, discontinue letermovir and begin anti-CMV therapy according to local practice.
4. If letermovir is co-administered with cyclosporine, the dosage of letermovir should be decreased to 240mg once daily.

Review of precertification requests for indications and/or duration of therapy in the above criteria will be reviewed by a clinical pharmacist and/or medical director.

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Updated 03/2018
Last reviewed 03/2018