Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Prevymis™ (letermovir)

Reset Form

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: _____

Drug information

☐ New request ☐ Continuation request

☐ Prevymis 240 mg oral tablet

☐ Prevymis 480 mg oral tablet

☐ Prevymis injection

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically-accepted indication*
   a. The FDA-approved indication is for the prevention of cytomegalovirus (CMV) infection and disease in adult CMV-seropositive recipients (R+) of an allogeneic hematopoietic stem cell transplant (HSCT)

Additional information

Note: When approved, coverage duration is limited to 100 days

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

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

Updated 05/2018
Last reviewed 05/2018

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Prevention of cytomegalovirus (CMV) infection and disease in an adult
- ☐ *Other – the patient's condition is:* _____

B. Has the patient received an allogeneic hematopoietic stem cell transplant (HSCT)?

- ☐ Yes
- ☐ No. ***Rationale for use:*** _____

C. Was the patient (e.g., the recipient of the stem cell transplant) CMV-seropositive (R+)?

- ☐ Yes
- ☐ No. ***Rationale for use:*** _____

Priority Health Medicare plans

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for drugs covered under Part B. If no national determination criteria (NCD) or local coverage determination (LCD) criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Prevymis likely be the most effective option for this patient?

- ☐ No
- ☐ Yes, because: _____

_____

_____

If the patient is currently using Prevymis, would changing the patient's current regimen likely result in adverse effects for the patient?

- ☐ No
- ☐ Yes, because: _____

_____

_____

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Updated 05/2018
Last reviewed 05/2018