SENTARA HEALTH PLAN

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Prevymis® (letermovir) **Injection for IV Infusion (J3490/C9399) (Medical)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

☐ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Quantity Limit (max daily dose) [NDC/HCPCS Unit]:

- 480 mg/24 mL solution per 1 vial; NDC 00006-5004-02; 1 billable unit per day
- 240 mg/12 mL solution per 1 vial; NDC 00006-5003-02; 1 billable unit per day

Recommended Dose: 480 mg IV once daily

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Diagnosis: Cytomegalovirus, prophylaxis in hematopoietic cell transplant recipients

Recommended Dose: 480 mg orally once daily. Initiate therapy between Day 0 and Day 28 post transplantation (before or after engraftment), and continue through Day 200 post-transplantation

Length of Authorization: 200 days of therapy

- ❑ Member is ≥ 18 years of age
- ❑ Member will be receiving Prevymis® for the prophylaxis of cytomegalovirus (CMV) disease
- ❑ Member is a CMV-seropositive recipient [R+] of an allogeneic hematopoietic stem cell transplant (HSCT)
- ❑ Medication will be initiated between day 0 and day 28, before or after engraftment
  - Enter date transplant was performed: _____
- ❑ Member is **NOT** receiving the requested medication beyond 200 days post-transplantation
- ❑ Provider must submit chart notes to document contraindication to therapy with oral Prevymis® tablets and rationale for medical necessity to continue IV Prevymis® therapy

❑ Diagnosis: Cytomegalovirus, prophylaxis in kidney transplant recipients

Recommended Dose: 480 mg orally once daily. Initiate therapy between Day 0 and Day 7 post transplantation (before or after engraftment), and continue through Day 200 post-transplantation

Length of Authorization: 200 days of therapy

- ❑ Member is ≥ 18 years of age
- ❑ Member will be receiving a kidney transplant
- ❑ Member will be receiving Prevymis® for the prophylaxis of cytomegalovirus (CMV) disease
- ❑ Member is at high-risk for CMV disease [documentation recording kidney donor is CMV-seropositive, and the recipient (member) is CMV-seronegative (D+/R-)]
- ❑ Medication will be initiated between day 0 and day 7, before or after engraftment
  - Enter date transplant was performed: _____
- ❑ Member is **NOT** receiving the requested medication beyond 200 days post-transplantation
- ❑ Provider must submit chart notes to document contraindication to therapy with oral Prevymis® tablets and rationale for medical necessity to continue IV Prevymis® therapy

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Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call Sentara Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****