SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Prevymis® (letermovir) **tablets (Pharmacy)**

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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limit:

- **480 mg tablets – 1 tablet per day**
- **240 mg tablets – 1 tablet per day**
- **120 mg oral pellets – 2 packets per day**
- **20 mg oral pellets – 4 packets per day**

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.

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❑ Diagnosis: Cytomegalovirus, prophylaxis in hematopoietic cell transplant recipients

Initiate therapy between Day 0 and Day 28 post-HSCT (before or after engraftment) and continue through Day 100 post-HSCT. In patients at risk for late CMV infection and disease, Prevymis® may be continued through Day 200 post-HSCT.

Recommended Dosage:

- **Adult and Pediatric Patients 12 Years of Age and Older and Weighing at least 30 kg:** 480 mg administered orally once daily

Recommended Dosage:

- **Pediatric Patients 6 Months to Less than 12 Years of Age or 12 Years of Age and Older and Weighing Less than 30 kg:**

Body Weight	Daily Oral Dose	Tablets	Oral Pellets
15 kg to less than 30 kg	240 mg	One 240 mg tablet	Two 120 mg packets
7.5 kg to less than 15 kg	120 mg	Not Recommended	One 120 mg packet
6 kg to less than 7.5 kg	80 mg	Not Recommended	Four 20 mg packets

Length of Authorization: 200 days of therapy

- ❑ Member is 6 months of age or older and weighs at least 6 kg
- ❑ 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

❑ Diagnosis: Cytomegalovirus, prophylaxis in kidney transplant recipients

Initiate therapy between Day 0 and Day 7 post-transplant and continue through Day 200 post-transplant.

Recommended Dosage:

- **Adult and Pediatric Patients 12 Years of Age and Older and Weighing at least 40 kg:** 480 mg administered orally once daily

Length of Authorization: 200 days of therapy

- ❑ Member is 12 years of age or older and weighs at least 40 kg
- ❑ Member will be receiving a kidney transplant
- ❑ Member will be receiving Prevymis® for the prophylaxis of cytomegalovirus (CMV) disease

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- ❑ 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 medication beyond 200 days post-transplantation

Medication being provided by Specialty Pharmacy – Proprium Rx

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.

***Approved by the Pharmacy and Therapeutics Committee:** ~~2/15/2018; 9/21/2023;~~ **11/21/2024**
REVISED/UPDATED/REFORMATTED: ~~6/21/2018; 1/9/2020; 10/17/2023, 12/17/2024,~~ **2/20/2025**