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:** _____

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:** _____

Quantity Limit: 1 tablet per day (all strengths)

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

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- ❑ 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

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 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 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
REVISED/UPDATED: 6/21/2018; **Reformatted** ~~1/9/2020;~~ **10/17/2023**